

## MASTER OF SCIENCE BY RESEARCH

### The ontology of asexuality a genealogical analysis of invisibility

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# **The Ontology of Asexuality: A Genealogical Analysis of Invisibility**

**By  
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MAR**

**September 2015**



# **The Ontology of Asexuality: A Genealogical Analysis of Invisibility**

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***A thesis submitted in partial fulfilment of the University's  
requirements for the Degree of Master of Research.***

## **Abstract**

This thesis traces asexuality genealogically through a series of thematically organised case studies by mapping ‘asexuality’ between late 19<sup>th</sup> and 21<sup>st</sup> century medical and psychological works and socio-political movements. By problematizing existing works surrounding asexuality and their definitions, the thesis argues that asexuality has been placed under erasure by Western capitalist societies that have understood sex as a consumer object, and rendered asexuality or a ‘lack’ of consumption of (hetero)sex, as characteristic of ‘bad economic subjects’. The research draws on Foucauldian (2003) genealogy to illuminate ignored or erased historical instances of asexuality in relation to specific socio-political contexts. My themes of medicalization, pathologization and politicization are understood as Deleuzian (1987) assemblages, with asexuality being a trace of a node within these assemblages. The thesis argues that asexuality is in fact not definable at all, and that rather than defining what asexuality may or may not be, it is instead more useful to consider how the heterogeneity of asexuality might challenge broader understandings of sexuality in Western society. Through Deleuzian (1987) theories of the assemblage, asexuality is understood as something with an agency of its own, which moves through the assemblages of medicalization, pathologization and politicization interacting with other nodes and changing the shape of both the assemblage and asexuality itself. The work therefore provides grounding for potential future studies on invisibility, asexual ontology, and the range of ‘new’ emerging sexual subjectivities that have been largely understood as a product of Web 2.0 and networked societies.

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## **Introduction**

The *Asexuality Visibility and Education Network* (AVEN) and its forums form an online community of self-identified ‘asexuals’. The *Asexuality Visibility and Education Network* was established in 2002 by college student David Jay after he reported struggling significantly in coming to his own identity as an asexual due to a lack of information and understanding around what asexuality might be (Mosbergen 2013). In recent years a growing field of asexuality studies has begun to emerge, alongside the online asexual community. However, as yet there is no research that has documented ‘asexuality’ prior to the Internet. Existing works on asexuality (see Carrigan 2011, Przybylo 2012, Scott and Dawson 2015, Scherrer 2008) have either understood asexuality purely discursively, or focused their attention on the contemporary asexual community through recruiting participants from the *Asexuality Visibility and Education Network* or analysing its forums. Przybylo and Cooper (2014) have argued for the development of a queer archive of asexuality, but as yet there has been no work published in response to this. There have been limited explorations of asexuality in historical medical contexts (for example see Przybylo’s (2012) work around the ‘scientific’ study of asexuality) but as yet there has been no work that maps asexuality historically throughout a range of situated contexts.

My research therefore seeks to trace asexuality historically through themes of medicalization, pathologization and politicization. In doing so, I draw together a series of case studies that map asexuality across different epistemes to examine the ways in which Western sex-centric society and ‘normative’ standards of sex have erased asexuality. I use my methodology chapter as an opportunity to explore how ‘normative’ sexuality has been constructed in Western society, before turning to my analysis to discuss how these conceptualisations of ‘normative’ sexuality have influenced the (in)visibility of asexuality. I argue that asexuality is not merely a product of web 2.0, but rather the *Asexuality Visibility and Education Network* can be considered a contemporary version of historic discourses in a broader becoming of ‘asexuality’. I map asexuality throughout historical texts through the lens of my themes, paying

attention to the absences and silences within these historical texts to illuminate historic instances or moments of what may be read as asexuality.

In researching asexuality I pay specific attention to the methodological considerations necessary for my research. In my methodology chapter I problematize existing works on asexuality, and the definitions they give. I address the ontological complications of how we can research an object that is claimed to be socially or culturally invisible and how we can research an object that is only understood to exist as a 'lack' or an 'absence' of something else. Etymologically 'asexuality' has documented instances as far back at the 19<sup>th</sup> century, where it was used in biological works to describe 'missing' sex organs, a definition also taken up by Krafft-Ebing (1886), whose work I examine in Chapter 3. The use of 'asexuality' has evolved somewhat since the 19<sup>th</sup> century; the prefix 'a-' is used commonly in the English language to communicate a 'without' or 'lack', hence asexuality has come to be framed in Western society as a 'lack' of sexuality. In order to work around the problematic nature of defining asexuality through a 'lack' of sexuality, I take up the work of Browne and Nash (2010). Using the work of Browne and Nash (2010) I argue that defining asexuality would dilute its political potential. Drawing on theorizing from Halperin (2009), I suggest that asexuality cannot be defined and propose that rather than defining asexuality it is instead more useful to look at the heterogeneity and complexity in its definition to consider how this might challenge Western understandings of sexuality more broadly.

My methodology chapter also outlines how my theoretical framework has been constructed, and the ways in which I deploy my methodology. I take a Foucauldian genealogical approach to my research in order to illuminate historical instances of asexuality that have remained unspoken, ignored or erased. I do so through a series of case studies which are examined in relation to their contexts, rather than aside from them, to highlight the ways in which asexuality has been constructed as invisible. In doing so I draw on Mazzei (2007) to examine how I might pay attention to the silences present in history and come to understand them as purposeful. I argue that listening to silences might enable us to disturb the taken-for-granted histories we are told, and reveal the heterogeneity of asexuality and its history. In listening to silences my



methodological approach draws on elements of Derridian (1997, 1993, 1976) thinking to conceptualise the silence of asexuality in Western histories as an absent presence. Using the work of Gordon (2011, 2008) and Cvetkovich (2003) I use my methodology chapter to consider how asexuality can be thought of as being haunted by historical traces. I combine multiple theoretical perspectives to build a methodological “tool box” (Foucault 1974: 523); through my approach I produce a multi-stranded analysis of the complexity of asexuality.

I further expand my theoretical framework to understand the themes my case studies are organized around as assemblages, enabling a reading of asexuality as something with an agency of its own, which moves as a trace of a node through assemblages, interacting with other nodes, and changing the shape of both the assemblage and itself. In drawing on Deleuze and Guattari (1987) I enable a focus on what asexuality can *become* as opposed to what it *is* or *is not*. Through a focus on what asexuality can *become* I explore the relationships between asexuality and other nodes within the assemblages of medicalization, pathologization and politicization, analysing how the trace of the node of asexuality is constantly drawn into territory’s of other nodes, changing the shape and value of both. I recognise the limitations of my work in terms of scope, and offer justification to the inclusion of my selected case studies, which map genealogically the history of asexuality and its invisibility.

In my second chapter I explore the medicalization assemblage in order to deconstruct historic medical works and their specific socio-historic contexts. This chapter negotiates the ways in which the medicalization of mundane experiences, such as pregnancy, food habits, balding or sex became pathologized through the binary separation of body/identity. I focus on the vast range of ‘cures’ proposed to treat ‘hysteria’ and ‘frigidity’ in the late 19<sup>th</sup> and early 20<sup>th</sup> Century, examining the ways in which a ‘lack’ or ‘absence’ of female orgasm came to be regarded as abnormal and in need of cure. I consider how the rise of enlightenment thinking alongside the eugenics and feminist movements enabled the cultural production of ‘hysteria’ and ‘frigidity’ and facilitated the definition of ‘scientific’ ideals of ‘normative’ sexuality. Maines’ (1999) documentation of the medicalization of female sexuality is used as the basis for my

initial case studies which analyse the ‘cures’ used to treat female ‘hysteria’ or ‘frigidity’, ranging from hydrotherapy to vibrators. The second case study provides an exploration of Viagra, and its associated conceptual evolution from the physiological cures of the late 19<sup>th</sup> and early 20<sup>th</sup> Century. I examine the ways in which capitalism and constructs of hegemonic masculinity have enabled the cementation of Viagra as a cultural icon. I highlight the ways in which asexuality is further erased through the framing of a ‘lack’ of sexual desire as problem in need of a cure, and explore how capitalist Western society has erased asexuals as ‘bad economic subjects’ due to their refusal to consumer (hetero)normative sex, and medical ‘cures’ such as Viagra (Lazzarato 2009).

In my third chapter I then turn to case studies of the works of Krafft-Ebing (1886), Kinsey (1948, 1953) and the Diagnostic and Statistical Manual (American Psychiatric Association 2013, 1994, 1987, 1980) to explore the pathologization assemblage. In this chapter I trace the categorization of an ‘absence’ or ‘lack’ of sexual desire as ‘psychiatric conditions’. I examine the invisibility of asexuality through the psyche, exploring the ways in which psychological works framed sexual desire as a necessity for ‘healthy’ mental functioning. I draw on the work of Krafft-Ebing (1886) as the basis for my first case study in this chapter, as one of the earliest Western works to name asexuality (despite the difference in definition to contemporary understandings); I pay particular attention to Krafft-Ebing’s (1886) exploration of instances of ‘lack’ or ‘absence’ of sexual desire. I analyse the field notes of Krafft-Ebing (1886) and his case studies of patients, drawing attention to the ways in which Darwinism and its promotion of biological essentialism, in combination with remaining traces of religion, influenced Krafft-Ebing’s (1886) understandings of ‘normative’ sexuality. I then turn to the controversial works of Kinsey (1948, 1953) to examine his privileging of physical response in his categorization of patients’ sexuality. I underline the mid-20<sup>th</sup> Century trend in behaviourism as contributing to Kinsey’s (1948, 1953) categorization of patients in accordance with their accounts of physical sexual response.

Kinsey's (1948, 1953) work categorized patients who he deemed to recall 'low' sexual response as 'X', a category he then excluded from his chart and neglected to analyse, despite recording it in his tables. I argue that Kinsey's (1948, 1953) 'X' patients become an absent presence of asexuality in his works. Given the dominance of psychoanalytic modes of thinking, research into sexuality became a growth area, and so with it a range of other researchers began to explore different psychosexual categories, which show a preference for heteronormative and heteropenetrative modes of sexual desire (see Freud 1951, Freud 1914, Lacan et al. 1982). Finally in my study of the pathologization assemblage I turn to the Diagnostic and Statistical Manual to examine how historical texts have continued to haunt contemporary lived experiences and categorizations of a 'lack' or 'absence' of sexual desire. I pay specific attention to the associated discourses that equated techno-science to progress, resulting in a shift in the Diagnostic and Statistical Manual's rationale away from psychoanalytic frameworks and towards bio-medical models grounded in 'science'. I explore the ways in which Foucault's (1989, 1977) discussion of mental health professions as part of a broader 'psy-complex' (Rose 1999) demonstrate how the categorizations presented by the Diagnostic and Statistical Manual have enabled the creation of a self-regulatory society. I argue that through its numerous revisions the Diagnostic and Statistical Manual has refused to legitimize asexuality, despite pathologizing asexual practices and experiences, and in doing so it has further marginalized asexuality.

In my fourth chapter I investigate the absent presence of asexuality within the politicization assemblage. I draw on the works of Plummer (1995) and Hemmings (2005) to provide a groundwork and exploration of how stories of various social and political movements have come to be told and remembered as linear, homogeneous and cohesive narratives of progress. Through my case studies I seek to highlight the fragmentation and heterogeneity present in social movements. I draw on case studies of the Gay Activists Alliance and feminist movements to highlight the erasure of asexuality from their histories before turning to a case study of the *Asexuality Visibility and Education Network* to examine how stories of liberation have shaped the contemporary asexual community and asexual activism.

I conclude by summarising the ways in which asexuality can be mapped across late 19<sup>th</sup> to 21<sup>st</sup> century medical and psychological work and histories of social movements. I argue that asexuality has been rendered invisible in capitalist Western society by discourses that frame the non-consumption of sex as a characteristic of a 'bad economic subject'. I draw attention to the discourses throughout late 19<sup>th</sup>, 20<sup>th</sup> and 21<sup>st</sup> century histories that have continued to erase asexuality. I argue that this work can be considered grounding for wider studies on invisibility, asexual ontology, and the increasing number of sexual subjectivities that have been largely understood to be a product of Web 2.0 and networked societies.

# **1. Methodology**

## **1.1 Introduction**

My research employs a genealogical approach, tracing asexuality historically through a series of thematically organised case studies based around themes of medicalization, pathologization and politicization. The case studies identified provide an exploration of silences surrounding sexual desire and attraction. I turn to silence and invisibility to provide an alternative account of what we might take asexuality to be without relying on typical historical accounts that have marginalized or erased asexuality so far. Previous works surrounding asexuality have employed a multitude of often-contradictory definitions that can be considered problematic both within the asexual community and to those researching the field. As a Trans identified researcher who rejects the binary and preclusive medically essentialist definitions of both sexuality and gender embraced by Western society, I find existing definitions of asexuality to be restrictive and feel that they fail to take account of the complexity and multiplicity of asexual identities.

Asexuality is often understood as the trace of Western understandings of sexuality through its positioning as being in binary opposition to sexuality, or as a 'lack' or 'absence' of 'normative' sexuality (Przybylo 2011). Barker (2011: 34) argues that "we live in a sex-saturated culture", but that "alongside...hypersexualisation there is an ever-increasing anxiety about sex and a concern with being unable to have 'functional' [or 'normative'] sex". Conceptualisations of 'normative' sexuality in Western society hinge on Western constructs of gender as a biologically innate and binary category; in Western society 'normative' sexuality has been framed as hetero-penetrative, taking place between a 'man' and 'woman', and resulting in (male) orgasm (Barker 2013). 'Normative' Western sexuality privileges masculinity, understanding the male as active, and the female as passive, during 'normative' intercourse. Male orgasm, achieved through penile-vagina penetration, is positioned as the ultimate goal of 'normative' sex (Barker 2011, Barker and Richards 2013, Denman 2004). Western standards of sexual normativity also rely on a linear progression of sexual intercourse, beginning with sexual desire, followed by sexual arousal and concluding with (male) orgasm (Barker 2011, Denman 2004). The linear model of sexuality frames all forms of sexual pleasure

outside of it as pathological, dysfunctional or abnormal, and also assumes sexual desire is universally experienced. Forms of sexuality outside of hetero-penetrative frameworks are frequently compared and measured against heterosexuality, and invariably understood as structured around gender (Barker and Richards 2013). As Barker (2013: 69) has written, asexuality “questions the number one rule that we currently have about sex: that it is a vitally important defining feature of relationships”. Asexuality also questions constructs of sexuality as reliant on gender and sex as being essential to ‘healthy’ relationships. Mainstream media and self-help cultures contribute to representations of sex as necessary for ‘healthy’ relationships, with thousands of print and web-based magazines dedicating pages to how to maintain ‘healthy’ relationships; their ‘answers’ nearly always revolve around sex (See Ratchford et al.’s (2015) discussions in *Cosmo*, *The Telegraph* (2015) and *Women’s Health Magazine* (2015)). Boynton’s (2015) article in *The Telegraph* suggests a ‘lack’ of sex in a relationship must be addressed either through counselling, separation, or an open relationship (enabling one or both partners to have sex with others). Whilst in some respects we can consider Boynton’s (2015) response as progressive, as it suggests alternative relationship models outside of monogamy, it also renders non-sexual relationships as inherently ‘unhealthy’, by privileging sexual contact above all other forms of engagement in the relationship. It is perhaps because of the ways asexuality troubles ‘normative’ Western understandings of sex and ‘healthy’ relationships that it has been rendered as preclusive to or outside of sexuality more broadly.

My research traces the ways in which discourses have positioned asexuality as being preclusive to or outside of sexuality. Contemporary accounts of asexuality have noted that there has been a continued emphasis by activists in the asexual community on the recognition of asexuality as biologically innate and preclusive of other sexual identities (Scherrer 2008). I map the ways in which assemblages of medicalization, pathologization and politicization have contributed to the understanding that (a)sexuality must be visible, innate and biologically determined in order to be legitimized (Carrigan, Gupta and Morrison 2013, DeLuzio-Chasin 2011, Przybylo 2011).

Therefore in contrast to existing works in the field my research avoids a fixed definition of asexuality, arguing that providing one would both exclude many self-defined asexuals and dilute the political potential asexuality can be said to harness as a refusal of Western sex-centric society's standards of sexual normalcy (Carrigan 2011, Scherrer 2008). In avoiding a fixed definition of asexuality I draw a comparison with work on bisexuality and queer definitions. I take Browne and Nash's (2010) argument that to define 'queer' would dilute its resistant and transgressive potential as my starting point. As Halperin (2009: 454) has argued of bisexuality, rather than providing definitive lucidity around what bisexuality does or doesn't mean, it is instead more useful to examine the "crisis of... definition" as productive for examining a more general and substantial "crisis in contemporary sexual definition".

In taking the same approach to my genealogical tracing of asexuality I attempt to complicate and examine the asexual "crisis of... definition" (Halperin 2009: 454) to provide a critique of the socio-political systems which have erased asexuality from traditional historical accounts. To do so, I employ elements of Deleuze and Guattari's (1987) theory of the assemblage. For me, the assemblage refers to a number of non-static, fluid and interconnecting objects or bodies within a shared context. I understand my themes as assemblages, each of which lacks definitive organization and finite structure, making them susceptible to change and development. Asexuality is understood as the trace of a node within the assemblages of medicalization, pathologization and politicization, moving through them with an agency of its own. This concept offers new understandings of asexuality, not as exclusive and oppositional to sexuality, but as something which has an agency of its own, moving through assemblages in constant flux, interacting simultaneously with socio-cultural contexts and power structures. I trace the historical operations and distributions of power thematically through assemblages of medicalization, pathologization and politicization drawing on the works of Foucault (2003) to disentangle discourses that have shaped contemporary asexuality (Currier 2003) and map the ways in which asexuality has been persistently erased from dominant historical narratives.

Despite rejecting a fixed definition of ‘asexuality’, I employ the term ‘asexuality’ as an analytic to critique histories that have privileged reproductive heterosexuality. Employing ‘asexuality’ as an analytic entails taking up the term ‘asexuality’ to critique historic accounts of (a)sexual practices. My approach avoids undue convolution and confusion in tracing asexual histories; it also illuminates erased instances of (a)sexual practices, and offers a more nuanced understanding of what we might take ‘asexuality’ to mean, and how we might research it as the object of study. I am aware that using the term ‘asexuality’ as an analytic is both inadequate and necessary in my research (Derrida 1976). The inadequacy of using the word ‘asexuality’ as an analytic is made clear by Derrida’s (1976) work, which argued that written words contain ‘traces’ that convey meaning, but simultaneously ignore or overlook alternate meanings; language “can only be a failure, a gap; ... since a word always points to an absence” (Frers 2013: 433). However, using ‘asexuality’ as an analytic becomes necessary to ground the project in relation to wider socio-cultural constructions of sexuality. Given asexuality has been understood by Western societies as an ‘absence’ or ‘lack’ of normative sexuality, in exploring asexuality genealogically I have traced (at least some of) the absences present within historical works on sexuality.

I do not define what an asexual identity category may or may not entail. However, in analysing asexuality genealogically I use these terms in an attempt to provide the foundation for my argument and prevent the discussion from becoming too abstract to offer any grounding for further research. Whilst genealogical enquiry is an abstraction in itself, I deploy genealogy in an effort to provide a basis for more productive and experience orientated research in the future by complicating contemporary reductive understandings of asexuality. In creating a historical account of asexual practices and experiences I illuminate previously erased or unspoken instances of what can be read as asexuality. I use the Deleuzian (1999) conceptualization of luminosity to describe the ways in which asexual histories come to exist as flashes, reflections or Derridian (1976) traces (Bogue and Spariosu 1994).

In tracing asexuality genealogically I recognise that the decisions I make in including or excluding case studies shape what the research re-presents as asexual histories. In



highlighting instances of asexuality historically I provide accounts of asexuality to ground potential future investigations. I have focused my research around Western historical texts, whilst I recognise the restrictions and implications that result from this, it has also been necessary to narrow my focus in order to produce work of sufficient depth to do justice to the complexity of asexuality. I narrowed my research to Western texts to determine how they have shaped contemporary asexuality, as the majority of existing works surrounding contemporary asexuality (see Carrigan 2011, Przybylo 2011, Scherrer 2008) focus on participants or data collected from the *Asexual Visibility and Education Network* forums, which are understood to be made up of largely Western, and indeed mostly American, members. There are a number of accounts of asexuality outside of white Western contexts emerging online via open and social media platforms (See *ace-muslim* (2015), *Asexual People of Color* (2015), and *The Thinking Asexual* (2015)), however due to scale, size and the risks of folding specified cultural and historical constructs into one overarching category, this project remains focused on compiling a – still always already selective - genealogical analysis of Western asexual ontology.

Studying asexuality involves the negotiation of multiple ontological complexities. There are ontological difficulties as to how something claimed to be culturally and socially invisible can be researched; these difficulties are compounded when researching asexuality by contemporary Western understandings that recognise the object of my research only in relation to an absence or ‘lack’ of something else. For example, Bogaert (2012: 5) describes “real-deal” asexuality as having “a complete lack of sexual attraction and/or sexual interest”. Bogaert’s (2012, 2006, 2004) contemporary sexology work has understood asexuality only in relation to Western understandings of normative sexuality, and othered it as an intrinsic and amorphous category. From this perspective, ‘lack’ entails uniformity. However, Bogaert’s (2012, 2006, 2004) work is contradicted empirically by the variety and multiplicity of identities put forward by the asexual community (Carrigan 2011). For example, the users of the *Asexuality Visibility and Education Network* forums (2015) are able to further categorize themselves by entering their own identification terms in a user information box that appears next to them when they post (see examples in Figure 1). The user information box allows space for user’s

to enter their Gender, Pronouns, Location and 'A/sexuality' (see examples in Figure 1). Identifications given are varied, diverse, and far beyond the restrictive medical essentialism of Bogaert (2012, 2006, 2004). My project seeks to avoid a fixed definition of asexuality, in order to prevent the exclusion of many self-identified asexuals whose identifications do not seem to fit into medically essentialist definitions of sexual orientation as biologically innate. Definitions of asexuality like Bogaert's (2012, 2006, 2004) are therefore problematic for my research as they deny individual agency and position asexuality as a 'lack' of sexuality.

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Figure 1. AVEN (2015)

Przybylo (2011) asserts that asexuality should be conceptualized based on what it *does* rather than what it 'lacks'. Building upon Przybylo's (2011) work I contest that rather than understanding asexuality in line with contemporary Western understandings that situate asexuality as a 'lack' or 'absence' of something else, we should locate silences surrounding asexuality as "*purpose full and meaning full*" (Kim 2011, Mazzei 2007: 9). Asexual practices are understood as

"neither fixed nor given, but as particular historical configurations of the material and immaterial captured and articulated through various assemblages which to some extent determine them as particular bodies, but never managed entirely to exclude the movement of differing and the possibility of becoming otherwise" (Currier 2003: 332).

In order to conceptualise historical asexual practices, identities and communities I therefore turn to Deleuze and Guattari (1987) to reconceptualise asexuality. I place

emphasis on asexuality's potential, and what it can *become*, rather than what asexuality *is* or *is not*. Through focusing on what asexuality can *become* I consider asexuality as the trace of a node within the assemblages of medicalization, pathologization and politicization (see page 19 for discussion of asexuality as the absent presence of the trace). In concentrating on what asexuality can *become* I enable an analysis of the processes of change that have placed asexuality under erasure within the assemblages of medicalization, pathologization and politicization (Deleuze and Guattari 1987, Derrida 1976). I seek to illuminate the “historical configurations of the material and immaterial” (Currier 2003: 332) through genealogical enquiry, paying attention to the infinite variability and simultaneous restriction in the ways these historical configurations have shaped asexuality. From a Deleuzian (1987) perspective assemblages territorialize bodies, setting limits on what the body can do or become and determining the shape of sexuality (Fox 2012). Fox's (2012) work, enables an understanding of asexuality as a fluid, ever-shifting entity, in constant flux; something which is both shaped by and shapes its context. Therefore, through my case studies I explore the ways that the assemblages of medicalization, pathologization and politicization have shaped asexuality, and the ways asexuality has shaped them. I use Deleuzian (1987) conceptualisations of territorialisation to demonstrate the simultaneous infinite variability and restrictiveness of sexuality (Fox and Alldred 2013). Another element of the work of Deleuze and Guattari (1987) I add to my ‘tool box’ of methodological ideas is the body without organs, which I understand as the way assemblages are embodied. The body without organs enables an understanding of contemporary asexuality as embodying the diverse and disparate nodes from the assemblages of medicalization, pathologization and politicization. Drawing on the concept of the body without organs, I pay attention to the ways in which asexual practices and embodiment can be understood as physically, politically and culturally emancipating from Western sex-centric society (Deleuze and Guattari 1987, Fox 2012).

In the above subsection I have outlined how through genealogical analysis I examine the relations between assemblages of medicalization, pathologization and politicization with asexual practices and asexuality as an embodied identity category (Fox 2012). Turning to Deleuze and Guattari (1987) enables a radically different conceptualisation

of asexuality and its interconnections within complex historical assemblages and social practices; “refusing to subordinate the body to a unit of a homogeneity of the kind provided by the bodies subordination to... biological organizations” (Grosz 1994: 165).

In the following subsection I now provide an in depth discussion of the methods and methodologies my research employs. I first turn to the works of Foucault (1980, 2003), Dean (1994) and Hook (2005) to explore how genealogy enables an alternative reading of asexual histories that draws upon silence as a subjugated knowledge. Following that, I consider what we might take invisibility to mean in relation to asexuality, and how we might research asexuality when it has been constructed as socially and culturally invisible. I argue that rather than a signifier of ‘absence’ or ‘lack’ moments of (a)sexual silence can be read as both transgressive and resistant and examine how the works of Cvetkovich (2003), Gordon (2008) and Mazzei (2007) will enable my research to move beyond definitions of asexuality as a ‘lack’ or ‘absence’ to conceptualize what asexuality might *become* (Deleuze and Guattari 1987).

## **1.2 Genealogy**

Though a genealogical tracing of asexuality, I seek to illuminate previously disguised, overlooked or unspoken instances of asexual practice. To achieve this I focus specifically on the invisible and the silent moments in sexual histories. Taking Foucault (2003: 8) as my starting point I employ genealogy to provide a re-presentation “of struggles and the raw memory of fights”. Foucauldian genealogy begins by de-centralizing “power-effects” of institutions and dominant discourses that are often overlooked by ‘official’ histories (Foucault 2003: 9). Through employing a genealogical approach I highlight the climates that have constructed asexuality as an identity category that is considered only to exist through ‘absence’ (Foucault 2003, Hook 2005). In tracing the construction of the identity category of asexuality I deconstruct historical knowledges to underline the socio-political climates that have erased asexual practices.

Genealogical analysis moves by attempting to illuminate subjugated accounts, in this instance of asexuality, to provide an alternative history (Hook 2005, Foucault 2003). The reactivation of historical climates considered alongside subjugated knowledges

disturbs the taken-for-granted ‘truths’ that have rendered asexuality invisible (Foucault 2003, Hook 2005, Smart 1983). For example, Foucault’s (2003) genealogical analysis of sexuality sought to deconstruct historical discourses alongside individual cases studies and challenged the taken-for-granted narrative of, for example, Victorians as sexually repressed. I deliberately draw on the absences present within histories of (a)sexuality, because their subjugation has prevented their assimilation to dominant discourses and systems of institutional power (Hook 2005, Foucault 2003). Subjugated knowledges produce an “opposition and struggle” (Foucault 1980: 85) against totalizing ‘truths’ and narratives of unity, generating a consciousness of the complexity and multiplicity of historical knowledges (Smart 1983).

For Foucault (1980) genealogy is the union of two forms of subjugated knowledge; the first is that of the historical contexts that are obscured or masked within traditional histories, the second being local knowledges which have been dismissed as unqualified or ‘false’. It is through the union of these two forms of subjugated knowledge that a disturbance and disruption of dominant discourses is enabled. In accordance with Hook’s (2005: 4) claim that “genealogy might enable the project of political criticism” I use genealogical approaches to gain insight into the ways in which socio-political climates have affected the construction of asexuality, disturbing dominant discourses and exposing totalizing ‘truths’. For Foucault (1997: 256) the disturbance of totalizing ‘truths’ gives us “something to do”. Foucault (1997: 256) argues that revealing the heterogeneity of history should lead “not to apathy but to a hyper- and pessimistic activism”. The disruption of dominant discourses and the “hyper- and pessimistic activism” it enables renders genealogy ‘effective’ (Dean 1994). It is through the disturbance and critique of taken-for-granted scientific ‘truths’ that the heterogeneity of histories is revealed (Dean 1994, Hook 2005).

The heterogeneity of discourses and histories are revealed through genealogy, making a ‘one rule’ truth discourse difficult to hold onto. Whilst my genealogical tracing of asexuality seeks to provide a history of the present, it also necessarily rejects the present as an ‘end point’ (Foucault 1977). Drawing upon Deleuze and Guattari’s (1987) concept of the rhizome and Dean’s (2006) application of genealogy, my research maps

asexuality with no explicit beginning, end, or finality. Instead my case studies are organised thematically, each exploring complex medicalization, pathologization and politicization assemblages. Although I recognise the orderliness of writing these accounts, these assemblages are non-linear, and rendered infinitely variable by the agency that passes through them. I pay attention to the diverse and heterogeneous make-up of my case studies within each assemblage, to avoid a linear and stagnant narrative of asexuality. I deliberately reject a teleological view of (a)sexuality, and apply a Deleuzian framework to Foucauldian conceptualisations of genealogy and power to fragment the cohesion of traditional accounts of (a)sexuality (Currier 2003). My research does not intend to provide an exhaustive history or genealogy of asexuality, rather it remains “always open to revision and extension” (Dean 2006: 217). I use case studies to complicate and critique conventional contemporary histories of asexuality that have erased, marginalized or ignored asexual identity or practices. And I document instances of (a)sexual practices in a way that troubles and disrupts previously recorded ‘truths’ and ‘knowledges’, that have constructed asexuality as a product of an online Western networked society. In doing so I seek to underline the multiplicity of both asexuality, and the ways in which it has been erased and rendered an absent presence within the assemblages of medicalization, pathologization and politicization.

For Foucault (1980), critiques enabled through genealogy’s refusal of assumed ‘truths’ and knowledges render genealogy ‘anti-science’; genealogies stand in opposition to dominant discourses and overarching narratives of ‘truth’. In opposing dominant discourses and narratives of truth genealogy becomes a “methodical problematization of the given” (Dean 2006: 216). Through genealogical investigation I problematize ‘the given’, examining the multi-stranded and complex ways in which asexual invisibility has been maintained through institutionalised systems and structures of power (Dean 2006, Hook 2005). In exploring the maintenance of asexual invisibility through institutional structures of power, I provide grounding to further study in to the ways in which these have been taken up by society (Dean 2006, Hook 2005). Genealogy will facilitate the re-presentation of asexual histories, presenting a challenge and disruption to totalizing ‘truths’ (Hook 2005).

For Hook (2007: 138) genealogy is a “methodology of suspicion and critique” that should disrupt the familiar and taken-for-granted knowledges, and their production. Disruption of the familiar is made possible through the deconstruction of the previously unseen, or ignored, to provide a critique of totalizing ‘truths’ and the institutional power structures that underwrite them. The case studies that are drawn on seek to highlight the institutional power systems by which (a)sexual knowledge has been bound to its production. I examine not only subjugated knowledges, but also the cultural contexts that have enabled their subjugation, and the ways in which the dominant discourses at the time have been produced. In opposition to traditional histories I highlight the heterogeneity of (a)sexuality to deconstruct the sense of unity created and upheld by dominant discourses that have constructed asexuality invisible or present only through an ‘absence’ of something else (Bogaert 2006, Kim 2011, McNay 1994).

The inclusion of subjugated knowledges in genealogical enquiry is vital due to the fact that they have not yet been assimilated into the ‘power-knowledge circuit’ (Ransom 1997). Subjugated knowledges therefore harness the potential to be transgressive and disruptive, to illuminate previously unacknowledged trajectories, and to destabilise established dominant discourses (Hook 2007). However, Foucault (1980) highlights that the de-subjugation of knowledge is not without risk. The de-subjugation of knowledges renders them vulnerable to assimilation to dominant discourses and makes their adaption to disciplinary power structures possible. For example, the decriminalization of homosexuality significantly changed the shape of the gay liberation movement (for analysis of the gay liberation movement see Chapter 4 pages 63-70). With the decriminalization of homosexuality in Western society gay activists and political movement’s focus changed and began to push towards Western heteronormative ideals of the family and the good life (Ahmed 2010), eventually leading to the legalization of gay marriage in England and Wales in 2014. Whilst the legalisation of same sex marriage might initially seem unproblematic, homosexuality has been assimilated to Western norms and ideals, and has resulted in the further marginalization of certain sections of the community; legislation was passed under the banner of ‘equal marriage’, however many members of society remain ‘unequal’ in spite of this legislation such as those in non-monogamous relationships, those who do not want to be in relationships

and Trans individuals whose marriages must be annulled in order for them to obtain legal 'gender recognition'. Therefore for Foucault (1980) the importance of maintaining a clear view of the purpose and objectives of genealogical investigation are paramount.

In employing genealogy I seek to disrupt medical, pathological and political narratives of asexuality. In line with Smart (1983), I look to highlight the instability of historical knowledges and the conditions by which they are produced rather than seeking to replace these with new and secure foundations for knowledge. It is the purpose of my research to employ genealogy "to fragment the cohesion of objects" (Hook 2007: 144), in order that dominant narratives of asexuality as existing only through 'lack' may be challenged, and its construction illuminated. For Hook (2005, 2007), Foucault's (1980, 2003) genealogy is not directed towards the revelation of a specific 'truth', rather its purpose is to provide a critique. Conversely, May (1993) argues that the critique genealogy generates does in fact construct new forms of 'truth'; through genealogical critique, new forms of knowledge are produced by the illumination of previously subjugated histories. However, in the case of asexuality there is a partial truth needed to move forward, and lay the groundwork for future research and activism. Truths generated by genealogy are not static, and are instead 'action-directed'; genealogically produced knowledges harness the potential to transform traditional histories and the present (Hook 2007, May 1993). While I am aware of the pitfalls of genealogical enquiry, I employ it in an effort to transform "the relationship that we have with ourselves and our cultural universe" (Miller 1994: 211). It is the transformative potential that genealogical enquiry harnesses that enables the illumination of asexual histories that have been previously ignored or erased.

Through genealogy I enable an analysis that takes account of how socio-political climates have facilitated the erasure of asexuality. I use genealogical enquiry to render visible the different dimensions of (a)sexuality, and to disturb notions of sexual desire as innate and 'natural' (Halperin 1995). Cvetkovich's (2003) work presents an archive as a method of situating micro-contexts of the personal within a "broader landscape" of society, in line with this my genealogical analysis seeks to bring together previously dismissed "local" knowledges (Foucault 1980) with socio-political climates to uncover



the ways in which they have simultaneously functioned to erase or keep hidden asexuality.

### **1.3 Invisibility, Silence and Haunting**

The difficulty of analysing a subject that cannot be seen, either through invisibility or through an existence only acknowledged through ‘absence’, makes asexuality particularly problematic for research. In his work surrounding the invisibility of whiteness Dyer (1997: 46) remarks “the subject seems to fall apart in your hands before you begin”. Heterosexuality can be considered synonymously to whiteness in this regard; the ‘given’ or ‘taken-for-granted’ becomes invisible through its normativity. In contrast, asexuality’s invisibility occurs through its opposition to the normative. Heteronormativity renders asexuality present, affective, yet invisible until verbalised. Asexuality can therefore be understood to “fall apart in your hands” (Dyer 1997: 46) as a strategy of Western sex-centric society. However, instead of examining the ways in which this falling apart may make it impossible to map sexuality, which would be a restrictive view on its history, the ‘absence’ might actually be considered a purposeful ‘presence’ that enables a re-telling of asexuality. Derrida’s (1976) notion of the trace allows me to consider the ways in which the erasure of asexuality leaves in its place an ‘absent presence’. In tracing asexuality I remain conscious that the ‘absent’ yet ‘present’, invisible, or silent moments of history are unavoidably connected to the present, and affect the ways in which the future will be shaped (Black 2011).

By giving equal value to the silences in my case studies as well as what is immediately visible, I “begin to hear the meanings dwelling within silence” (Johnson 2011: 59). I draw upon the work of Mazzei (2007) to consider how the invisibility or ‘silence’ surrounding asexuality can be drawn upon as something that is productive rather than restricting. Mazzei (2007: 29) suggests exploring the silence as both “*meaning full and purpose full*” (emphasis in original). In turn I apply this to asexuality itself, arguing that rather than defining asexuality through ‘lack’ we should avoid a fixed definition and explore the trace left by its silence, in order that individuals may find their own meaning and purpose in asexuality.

To complement Mazzei's (2007) work surrounding silences, I bring to the discussion Cvetkovich's (2003) *Archive of Feelings*, which offers one approach of deconstructing historical knowledges. Cvetkovich (2003) uses oral histories, memoirs and memories to archive invisible histories, preserving the past and contextualising invisible traumas of the present. One such example is Cvetkovich's construction of an archive of AIDS activism comprised of oral histories of lesbian AIDS activists, which serves "to keep the history of AIDS activism alive and part of the present" (Cvetkovich 2003: 6). As Gordon (2008: 195) argues, "to write a history of the present requires stretching toward the horizon of what cannot be seen with ordinary clarity yet". The work of Gordon (2008) too therefore investigates the ways that invisibility can "haunt the present" (Cvetkovich 2003: 6), calling to attention to the political potential of invisibility enabled through the disturbed relationship between what is speakable and what is knowable in haunted categories such as asexuality (Scherrer 2008). Kuntsman (2011: 5) summarises Cvetkovich's (2003) work as "*making the past matter*" (emphasis in original), highlighting the particular usefulness of the archive to document histories that have been erased through political structures such as heteronormativity. Cvetkovich's (2003) work can be used to further deconstruct the ways in which sex-centric Western society has further rendered instances of asexuality invisible, so that it can be said to haunt contemporary understandings of sexuality, thus creating asexuality's critical and deconstructive potential.

I deploy the work of Gordon (2008), Black (2011), and Cvetkovich (2003) as reference to consider the reasoning for absences and invisibility in relation to asexuality. In bringing together socio-political context alongside instances of asexual invisibility and erasure I enable a politically charged critique of the dominant discourses that have marginalized or ignored asexuality. In my research I therefore consider historical case studies in relation to the context through which they were produced and their wider relation to other works within the medicalization, pathologization and politicization assemblages, to enable the mapping and re-presentation of erased (a)sexual histories. I draw on Cvetkovich (2003) to enable the mapping and re-presentation of erased (a)sexual histories. My research understands the invisibility and erasure of asexuality as "haunt[ing] the present" (Cvetkovich 2003: 6). Through Foucauldian (2003) genealogy

I intend to re-present the history of asexuality, drawing on instances of erasure and invisibility that “haunt the present” (Cvetkovich 2003: 6).

Gordon (2011, 2008) also considers haunting as a unity of strategic power-systems and meaning. Power systems that facilitate the erasure of asexuality “make themselves known and their impacts felt in everyday life” (Gordon 2011: 2). For example, the criminalisation of suicide persists to haunt contemporary discourses and language, suicide is still referred to in Western society as an act that is ‘committed’ akin to the way we refer to crimes, and suicide ‘prevention’ charities such as PAPYRUS (2015) put the onus of suicide prevention on the individual, rather than society. In a similar way, the shaping of the object through haunting is explored through my case study of the *Asexuality Visibility and Education Network*. I employ the notion of haunting to highlight the importance of re-presenting asexual histories in order to enable a broader reading of what asexuality might be. I seek to use the work of Gordon (2011, 2008) and Cvetkovich (2003) to explore their conceptualisations of haunting. I posit that haunting can be considered a form of affective invisibility; an invisibility that has shaped contemporary asexuality, and enabled asexuality to function as an absently present node within the assemblages of medicalization, pathologization and politicization. Haunting can be understood as an affective invisibility that occurs in the unseen or undocumented moments and instances in (a)sexual histories, that shapes lives or futures. I argue that the analysis of affective invisibility enables an alternative history to (a)sexuality that can destabilise the normative, and understand asexuality as a grounds for re-thinking “the centrality of sex” (Przybylo and Cooper 2014: 298) rather than understanding it in relation to an ‘absence’ or ‘lack’ (Foucault 2003, Hook 2007).

The affectivity of invisibility in shaping futures is illuminated through careful genealogical deconstruction of the unseen or erased. In deconstructing the unseen or erased moments of asexual history I am able to provide an account of the multiplicity present in contemporary asexual identity. The pre-verbal quality of affective invisibility is used as a means to open up binaries “in order to ‘hear’ that which has been previously discounted, disregarded, or unobserved” (Mazzei 2007: 71) due to its inaccessibility through language. Moments that have remained invisible or that have been silenced

through language are carefully deconstructed using the Derridian (1976) notion of the trace. Paying attention to the invisible and focussing on the power-systems that have constructed typical histories enables a deeper understanding of asexuality, its invisibility, and how that might be experienced in contemporary society through haunting (Foucault 1980, Gordon 2008, Mazzei 2007).

#### **1.4 Conclusion**

In conclusion to this chapter, my thesis thematically analyses case studies of traces of ‘absence’ and ‘silence’ surrounding (a)sexuality, deconstructing the discourses that have contributed to the privileging of heterosexual desire throughout history. In doing so I seek to illuminate the ways in which (a)sexual practices outside of heteropenetrative and reproductive sexuality have come to be defined through lack. Through deconstruction of discourses that have contributed to the maintenance of (a)sexual invisibility throughout history, I build a methodological framework for researching identities claimed to be culturally or socially invisible. I map traces of (a)sexuality throughout the history of hetero-sex, demonstrating the ways in which non-desire becomes understood as something that must be ‘fixed’, erased, or understood as being outside of Western conceptualisations of sexuality. I employ Derrida’s (1976) notion of the ‘trace’ alongside conceptualisations of haunting (Cvetkovich 2003, Gordon 2008) to highlight the importance of re-presenting asexual histories in order to enable a broader reading of what asexuality might be and do. I seek to explore haunting as an affective invisibility, that enables an alternative history to (a)sexuality to destabilise the normative, and understand asexuality as a grounds for re-thinking “the centrality of sex” rather than understanding it in relation to an ‘absence’ or ‘lack’ (Foucault 2003, Przybylo and Cooper 2014: 298). Historic discourses can be understood as haunting contemporary Western understandings of asexuality, thus Derrida’s (1976) notion of the ‘trace’ is methodologically central to my project, in terms of opening up space “in order to ‘hear’ that which has previously been discounted, disregarded, or unobserved” due to its absence or inaccessibility (Mazzei 2007: 71).

## **2. Vibrators and Viagra: From Biology to Chemistry**

The 2012 episode of Fox Network TV series *House 'Better Half'* (2012), features a couple that self-identify as asexual. The main characters Wilson and House discuss the patients, with Wilson informing House “close to 1% of the population identifies as asexual”. House is quick to dismiss Wilson’s claim of asexuality as legitimate betting \$100 that he can find a “medical reason” why the patient doesn’t want to have sex. House goes on to argue that sex “is the fundamental drive of our species” and “lots of people don't have sex” but “the only people who don't want sex are either sick, dead or lying” (*House: Better Half* 2012). House (*House: Better Half* 2012) simultaneously frames asexuality as something ‘abnormal’, devoid of agency and deceptive; House’s argument positions asexuality as something undesirable, unwanted and in need of prevention. Positioning people who “don’t want sex” as “sick”, renders asexuality as something in need of a ‘cure’, whilst “dead” implies they are devoid of agency and do not have the capacity to make conscious decisions for themselves (*House: Better Half* 2012). The implication that if you “don’t want sex” you must be “lying” is also problematic, as not only does it position asexuality as pathological but also as being fictitious, a myth, or deceitful (*House: Better Half* 2012). The episode resolved with the patient being ‘cured’ of their asexuality, after House determines “high levels of prolactin” are responsible for the ‘patients’ ‘lack’ of sexual desire (*House: Better Half* 2012). *House: 'Better Half'* (2012) contains traces throughout of historic medical practices that have framed (a)sexuality, (a)sexual practices, or anything outside of hetero-penetrative conceptualisations of sex as a physical ‘sickness’ in need of medical cure through the assertion that anything outside of hetero(penetrative) or procreative sex is ‘unnatural’ and a biological sickness. In the following chapter I explore the underlying presence of (a)sexuality in which historic medical discourses that have constructed (a)sexuality in way which haunts representations of asexuality in contemporary Western popular culture and allows *House: 'Better Half'* (2012) to make sense.

The following chapter provides an exploration of the medicalization assemblage and the ways in which it has contributed to the maintenance of the invisibility and erasure of asexuality. I deconstruct historic medical works paying close attention the socio-

political contexts through which they were produced and to the absent presence of the trace of (a)sexuality within each. I first explore the medicalization of hysteria and frigidity through the use of vibrators and hydrotherapy to examine the ways in which a 'lack' of female orgasm became located as a 'disease' that necessitated treatment. Following an exploration of hysteria I turn to Viagra as one of multiple contemporary 'cures' to 'sexual dysfunction'. Throughout I consider the ways in which the affective invisibility of asexuality in these case studies has shaped the landscape of more contemporary medically orientated conceptualisations of asexuality, such as those from Bogaert (2012), that regard asexuality as an innate 'lack' of sexual desire or attraction.

The medicalization of sexuality occurred as a response to the rise of enlightenment thinking in the late 18<sup>th</sup> century. Enlightenment thinking promoted the increase of scientific discourse through knowledge being equated with science and reason (Venn 2006). Lyotard (1988: 31) describes the Enlightenment as propagating ideas that "the enhancement of the whole of humanity" is achievable "through the development of capitalist technoscience". New information was 'discovered' in relation to sexuality during the 18<sup>th</sup> century, which was taken to bolster traditional Christian notions that marriage was a necessary condition for (hetero)sexual expression (Potts 2002). Enlightenment thinking placed emphasis on individuals and their autonomy "rather than that of religious doctrine" (Venn 2006: 478). Despite the re-organization of society around 'reason' and science, religion has persisted to be a prevalent factor in society up until the present day. Instead of replacing religion completely the Enlightenment's ultimate aim was 'progress'. The Enlightenment's definition of 'progress' as creating a more efficient society relied on the notion that there was a 'superior' and 'natural' state to aspire to in all aspects of life, including sexuality. Through organizing both social and political climates around 'scientific progress', the shift towards enlightenment thinking created space for new modes of governmentality and new forms of regulation.

One form of institutional regulation to emerge in response to enlightenment thinking was medicalization. The medicalization of sexuality occurred over time in response to 18<sup>th</sup> century enlightenment thinking and became a significant intellectual trend for Western society during the 20<sup>th</sup> century. Medicalization entailed the re-definition of life

experiences into objects of medical analysis and regulation (Tiefer 1994). Medicine therefore came to “exercise authority over areas of life not previously considered medical” (Tiefer 1994: 365). Tiefer (1994) identifies two major movements within medicalization, the first of which reframes previously criminal, sinful or anti-social ‘acts’ as the domain of medicine, whilst the second redefined common (largely physical) life events as medical ‘problems’. Rose remarks that discourses, such as medicalization, structure both experiences and languages and require “us to speak of ourselves in particular vocabularies, to evaluate ourselves in relation to certain norms” (1997: 234). For Foucault (2004) ‘norms’ form the foundations of power structures that transform subjects; “the norm brings with it a principle of both qualification and correction” (2004: 50).

Reissman (1983: 3) concludes medical professionals sought “to medicalize experience because of their specific beliefs and economic interests”. The medicalization of individuals occurs through what Foucault (1989) calls ‘the medical gaze’. As a disciplinary technology ‘the medical gaze’ implements a dichotomous split between identity and body; experience and identity are discounted as untrustworthy and insignificant in favour of biology (Foucault 1989). The ‘medical gaze’ focused the attention of doctors on what could be physically observed in a patient, privileging physiology above the psyche and positioning ‘patients’ as “passive object[s] subject to medical intervention” (Bell 2009: 152). Through creating a binary separation and hierarchy of body/identity, medical practitioners are able to focus their attention on the physiology of sex and ‘symptoms’ which are removed from individual circumstance to create ‘one-size-fits-all’ models of ‘treatment’; “the ‘artificial’ diseases of the hospital permit pathological events to be reduced to the homogeneous” (Foucault 1989: 135). Anything considered outside of the ‘norm’ was categorized and put under the medical gaze in order to be ‘treated’ and bring subjects back into line with societal standards (Foucault 2004, Foucault 1989). It is the medical gaze that has served to enable the institutionalization of heteronormativity and self-regulation (Foucault 1980).

The medicalization of sexuality relies on the assumptions that there is a normative standard of sexuality to aspire to (hetero-penetrative), and that everybody knows what

normative sexuality is, and is capable of or desires to perform sexuality in such a way (Tiefer 1994) (for a discussion of ‘normative’ sexuality see pages 7-8 in the previous chapter). The conceptualisation of ‘normative’ standards is tied heavily to the Western adaptation of statistics in the 18<sup>th</sup> century and its adoption by the eugenics movement (Davis 2006). Through numerical data, eugenicists are able to construct a statistical ideal of the ‘norm’, and thus the opposite: the deviant body (Davis 2006, Meleo-Erwin 2012). Medical and psychiatric models of ‘treatment’ use measurement and calculation to enforce a binary separation of the ‘normal’ and ‘deviant’ or ‘pathological’ (Foucault 1989, Laquer 1990). For Laqueur (1990: 188) medical control is implemented through the “strip[ping] away [of] individual differences, affective and material, so as to perceive the essence of health or disease in organ tissues”. Laquer’s (1990) definition of medical control strongly implies that the body can be fixed, where as morals cannot. By separating ‘normal’ and ‘pathological’ bodies, and situating sexuality as a problem of the ‘body’ rather than of morals, medical institutions were able to build an economy on the principle that they could ‘fix’ the body. By claiming that medical practices and institutions were able to ‘cure’, ‘fix’ and improve the body, models of medicalization fitted in with the Enlightenment’s quest for progress. In turn medical establishments were able to construct discourses of abnormal sexuality, which could be ‘cured’ by medical professionals rather than through moral guidance or religion (Downing, Morland and Sullivan 2015, Tiefer 1994). Reissman (1983: 3) concludes that medical professionals sought “to medicalize experience because of their specific beliefs and economic interests”.

The decline of religion made way for a rise in discourses of technological solutions and individualism, enabling a growth in the medicalization of social experiences (Conrad 1992). Medicalization entailed the re-definition of life experiences such as pregnancy, balding, grief and menstruation into objects of medical analysis and regulation (Tiefer 1994). Medicine came to “exercise authority over areas of life not previously considered medical” (Tiefer 1994: 365). Medicine claimed to offer the origins and ‘cures’ for ‘abnormal’ social or physical ‘problems’ (Potts 2002). Tiefer (1994) identifies two major movements within medicalization, the first of which reframes previously criminal, sinful or anti-social ‘acts’ as the domain of medicine, whilst the second



redefined common (largely physical) life events as medical ‘problems’. Both ‘moral’ and the ‘physical’ life events in regards to sexuality were redefined as medical ‘problems’ (Tiefer 1994). I draw upon the history of vibrators in ‘treatment’ of hysteria to further explore the redefinition of social and ‘physical’ experiences into medical ‘problems’.

In the following section I deconstruct the assemblage of medicalization focusing specifically on ‘hysteria’, ‘frigidity’ and the medical ‘cures’ that were used to ‘treat’ women as a result. I pay attention to the traces of (a)sexuality within the history of hetero-sex and the ways in which ‘absence’ or ‘lack’ become understood as deviant and abnormal. I trace the discourses and socio-cultural contexts that led to the medicalization of female ‘hysteria’ and ‘frigidity’ listening to moments of silence around ‘normative’ sexuality in order to locate (a)sexuality as meaningfully present and simultaneously erased.

## **2.1 Hysteria, Frigidity & Vibrators**

Despite the dismissal of the terms ‘hysteria’ and ‘frigidity’ in contemporary medical practice, their conceptualisations persist to haunt contemporary discourses of sexuality; “many psychiatrists and sexologists of our time continue to elaborate a complex network of ways in which women can be considered abnormally lacking in desire, pleasure or orgasm” (Cryle and Moore 2011: 8). Hysteria was conceptualised historically as a varied and vast range of ‘symptoms’ that collected any otherwise untreatable social, physical or psychological ‘ill’ into one ‘medical’ category. In ancient Greece up and in European medicine prior to the late 19<sup>th</sup> century hysteria was considered an innate female pathology caused by a random ‘wandering’ of the womb around the body (Richardson 2003). As Bell has highlighted, medical epistemology has drawn on the Enlightenment’s masculinist conceptualisations of ‘norms’, implicitly positioning ‘woman’ as always “the unhealthy, abject fail to its model man...woman’s unruly body...then warrant[s] her containment via masculinized medicine” (2009: 153). Causes of hysteria in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries ranged from drinking too much tea, to irregular periods and impotent husbands (Hock 2011). Similarly, frigidity was presented in ‘medical’ and fictional literature alike as “an utter lack of desire” or

“an inability to satisfy desires that were actually present” (Cryle 2008: 118). During the 19<sup>th</sup> century frigidity came to be considered as a wide spread female phenomenon and ‘ill’, present in “all women who criticise[d] or resist[ed] domination by men”, both hysteria and frigidity denied agency to women and served to regulate masculine defined ‘norms’ of sexuality which positioned male orgasm, achieved through penile-vagina penetration as the ultimate aim of sex (Cryle 2008: 128) (see pages 7-8 in the previous chapter for further discussion of ‘normative’ sexuality in Western society). I therefore turn to Maines (1999) documenting of the cultural history of vibrators to trace the medicalization of (a)sexuality. I employ the works of Derrida (1976, 1993, 1997), Mazzei (2007) and Gordon (2008, 2011) in order to deconstruct the ways in which medicalization, the dominant discourses it constructs, and the absences present within them have shaped contemporary understandings of (a)sexuality.

This subsection predominantly deals with the technologies used to ‘treat’ frigidity and hysteria. However, before turning to address these I discuss one ‘technique’ afforded relatively little attention in medical documentation; rape. Whilst rape is scarcely named in historic literature its trace remains. Eichenlaub’s (1967: NP) work remarked “a woman should never turn down her husband on appropriate occasions simply because she has no yearning of her own for sex or because she is tired or sleepy, or indeed for any reason short of a genuine disability”. As Gavey (2005) has highlighted women’s sexual desires, pleasures, wants or needs were neglected by social contexts that privileged men. In contemporary terms it is clear that Eichenlaub’s ‘marriage guidance’ condones, in no uncertain terms, non-consensual sex, because it is a woman’s ‘duty’ to provide her husband with sex, and she “should never turn down her husband” (1967: NP). In this sense, rape was understood as impossible within marriage. “The task of defining the truth of sex, [and] rape... was left in the hand of [largely male] scientific and medical experts” (Gavey 2005: 19), leading to rape being understood as “a violent and dangerous man grabbing a woman in a dark street, or breaking into her home at night” (Gavey 2005: 1). The definition of rape as only occurring between strangers meant that ‘real’ rape was considered a rare occurrence, despite the idea that having sex with her husband was an obligation for women.

With sex considered obligatory for wedded women, medical ‘concern’ about sexual dysfunction steadily increased throughout the 19<sup>th</sup> Century. Medical works promoted the idea that women who did not get married and fulfil their obligations to their husbands could become ‘insane’, helping to enforce the expectation that women should have sex. Harvey (1847: 189-190) describes young women who “continue too long unwedded” as being “seized upon with serious symptoms” remarking “women occasionally become insane through ungratified desire”. However, Lunbeck notes that hypersexuality was also ‘identified’ “as an issue of pressing medical concern” (1987: 513) by prominent Western psychiatrists during the early 20<sup>th</sup> century. Hypersexuality was a diagnosis only available to women, sexual curiosity was deemed normative for men, where as for women any sex outside of marriage was deemed as “abnormally aggressive” (Lunbeck 1987: 513). Hypersexuality was considered “an inborn condition for which there was no remedy save institutionalization” (Lunbeck 1987: 513). Case files from the Boston Psychopathic Hospital revealed hypersexuality was diagnosed in primarily younger women, nearly always of working class backgrounds (Lunbeck 1987). The medicalization of both hyper-sexuality and hypo-sexuality made ‘normative’ standards of sexuality increasingly impossible to achieve or conform to.

Maines (1999) tracks the development and evolution of the medicalization of womens sexuality, noting a series of complex and interconnected discourses that enabled the production of vibrators as a legitimate ‘cure’ for a ‘lack’ of female orgasm. Religious discourses that had framed hetero-penetrative sexuality as the only ‘natural’ and acceptable form of sexuality persisted to haunt 19<sup>th</sup> century Western medicine (Downing, Morland and Sullivan 2015, Foucault 1978). Rose (1997) argues that the argument that medicine and ‘psy’ have taken the place of religion is too simplistic. As Derrida (1997: 6) remarks, the establishing moment of an institution, whilst producing new discourses, “also continues something, is true to the memory of the past, to a heritage”; the institution of medicine can be understood as being true to the “memory” of religion in its preservation of heteronormativity. Bullough (1994: 23) documents the medical profession as regarding ‘unnatural sex’ as “worse than almost any other disease for it...gradually took away life itself”. While religion enforced heteronormativity or abstinence through doctrine that identified sexuality outside of hetero-penetrative and

reproductive sex as sinful, medicine maintained heteronormativity in the same way through reasoning that the ‘progress’ of the species was dependent on reproduction and that to not practice sexuality that supported reproduction was unnatural and abnormal (Potts 2002).

Medicalization is haunted by assumptions of religion that assume both that there is a normative standard of sexuality, and that normative sexuality is something that everybody aspires to (Tiefer 1994). Normative Western standards of sex are understood to be between a man and a woman, involve penile penetration of the vagina, and result in (male) orgasm (for further discussion of normative Western standards of sex see pages 7-8 in the previous chapter). We are held to normative standards of sexuality by the endless number of sexual ‘dysfunctions’ listed in medical works; these currently include: Premature Ejaculation, Delayed Ejaculation, Female Sexual Interest/Arousal Disorder, Female Orgasmic Disorder, Penetration Disorder, and Male Hypoactive Sexual Desire Disorder, to name just a few (American Psychiatric Association 2013, Barker 2013). In addition, cultural artefacts that propagate heteronormativity such as advertisements, cinema and literature continue to enforce the idea that ‘normative’ standards of sexuality are more desirable and should be aspired to (Barker 2013). However, such standards become impossible to inhabit; Barker (2013: 61) acknowledges that normative standards of sexuality “actually causes people to have sexual problems which they wouldn’t have if the kind of sex that they found most pleasurable was considered just as normal as penis-in-vagina intercourse”. Medical works render sexual activities outside of hetero-penetrative monogamy as ‘unnatural’, ‘dysfunctional’, ‘unhealthy’ and ‘abnormal’. Foucault (1978: 3) documents heterosexuality as an enforced norm that “safeguarded the truth, and reserved the right to speak while retaining the principle of secrecy”. Barker (2013: 63) writes that the Western quest “to find evidence that sexualities can be explained by biology in order to provide their legitimacy” relies on the assumption that somehow biologically innate characteristics are more ‘natural’ and are therefore “more acceptable or good”.

As a result of lingering religious discourses that have framed pro-creation as the ultimate aim of existence, a ‘lack’ or ‘absence’ of visible orgasm became framed as a

‘sickness’ in need of a cure. Because medicine draws on masculine constructs of the ‘healthy’ body, historically mutual orgasm was understood as central to pro-creation (Lloyd 2005); a ‘lack’ or ‘absence’ of orgasm in women came to be understood to be undesirable and a symptom of infertility and sexual dysfunction. Frith (2014: 1) points out that “despite detailed scientific scrutiny and close attention to bodily signs, the authenticity of women’s orgasm remains a site of cultural anxiety”. Though framed as necessary and ‘natural’ female orgasm is also constructed “as inherently invisible or un-see-able” (Frith 2014: 1). Despite being ‘invisible’ or ‘un-see-able’ (Frith 2014), female orgasm was considered to be the only ‘cure’ for hysteria in the early 20<sup>th</sup> century (Maines 1999). For Foucault (1978) hysteria is “an effect of power’s saturation of women’s body” (Grosz 1994: 157). Dominant narratives of 19<sup>th</sup> century frame the West as sexually repressed and conservative. Since the development of the bourgeoisie, activities that were simply for gratification were frowned on, sex became a private affair that was only considered legitimate if it took place within the confines of heterosexual marriage (Foucault 1978). Foucault (1978) analyses the ways that sex outside of heterosexual marriage was rendered unthinkable and unspeakable, aside from in a specific ‘outlet’ for confession; psychiatry. However, despite the dominance of the repressive hypothesis in public discourse, Foucault (1978) argues that 19<sup>th</sup> century Western society was in fact entirely organized around sex. Hystericization resulted in women’s bodies being “equated with sexuality, appropriated by pathology and identified with the social body” (Beizer 1994: 232), largely to serve the desires of men.

Through the “hystericization of women’s bodies” heteronormative sexuality was reinforced as the most ‘natural’ and only legitimate sexuality (Foucault 1978: 104). Despite hetero-penetrative sex failing to produce orgasm in most women, masturbation or any sexual activity outside of heterosexual monogamy continued to be framed as ‘morally wrong’. Jagose (2010: 525) notes that “women’s erotic capacities and requirements” are “so little valued or understood that women routinely simulated orgasm in heterosexual intercourse”, the masculinization of sexual desire and privileging of men more widely ensured women’s (hetero)sexual pleasure was afforded little concern. Boyle (1993) has argued that anxieties over female sexual (dys)function arose as a consequence of the threat that women’s sexual dissatisfaction posed to

heterosexual marriage and the nuclear family. Such anxieties enabled the construction of non-penetrative sex as 'morally wrong', and "relegated the task of relieving the symptoms of female arousal to medical treatment"; producing clitoral orgasm was framed solely as a medical procedure, non-sexual, and therefore morally unproblematic (Maines 1999: 3). The masculinisation of sexual desire alongside "asymmetrically gendered access to sexual pleasure" (Jargose 2010: 528) enabled the assertion that female orgasm was a "crisis of disease" (Maines 1999: 7) and meant heteronormativity and sex-centrism went unchallenged. The privileging of male sexual desire over that of women, constructed women's sexual dissatisfaction as symptomatic of an innate female 'problem' or 'disease', rather than a problem with heteropenetrative models of sex. The idea that heteropenetrative sex might not be the most pleasurable form of sexual stimulation for women was inconceivable as a result of discourses that promoted heteropenetrative sex as both a 'necessity' and the 'norm' (Jargose 2010).

Positioning any expression of sexuality outside of hetero-penetrative sexuality as not the "real thing" meant medical massage or stimulation of the clitoris or vulva was not considered sexual (Maines 1999: 10). Hydrotherapeutic 'cures' for hysteria arose during the late 18<sup>th</sup> century and were housed in private clinics or spas, where the 'patient' would be exposed to pressurised streams of water in an attempt to stimulate orgasm (Maines 1999). Scoutetten (1843: 239-241) detailed hydrotherapeutic 'cures' for hysteria, commenting "the first impression produced by the jet of water is painful, but soon the effect of the pressure...create[s] for many persons so agreeable a sensation that it is necessary to take precautions that they do not go beyond the prescribed time". Taylor (1885) also argued treatment for female hysteria should be supervised by physicians at all times to prevent 'overindulgence', or encourage the onset of 'hypersexuality' (Lunbeck 1987).

Maines (1999) concludes that hydrotherapy would have been prohibitively expensive for all except the upper-middle classes due to travel expenses, as well as treatment costs. Comparisons can be drawn between the medicalization of female hysteria and the criminalization of drug addiction in contemporary society; Maines (1999) work suggests that the wealthy would have accessed hydrotherapy to 'cure' their hysteria,

whilst the poor would have ended up in asylums, in a similar way to wealthy drug addicts going to rehabilitation centres, whilst poorer demographics are often caught up in Western judicial systems and go to prison. The expense of hydrotherapeutic ‘cures’, both for patients and in terms of installation costs, limited their use and led technologists to pursue more portable and accessible ‘solutions’ (Maines 1999).

Trower (2012) reports vibration had been frequently mentioned in medical journals since the 1860’s, where vibration from railways, sewing machines and bicycles were recurrently listed as a cause of concern in regards to sexual transgression. Ellis (1927: 217) went as far as to argue the sewing machine was capable of “exciting auto-erotic manifestations” and could lead to masturbation, “nocturnal emissions” and directly cause involuntary orgasm. However, it took relatively little time for medicine to capitalize on developments in new technology. Rockwell (1867) claims the first electro-mechanical vibrators were introduced to medicine in 1878 in response to complaints from physicians that manual massage was too time consuming in contrast to new technologies. Technologies are understood as something that enables human beings to “*extend beyond*” their own “limitations, physical, existential, psychological, or otherwise” (Boulter 2005: 54). William (1906: 56) argued manual massage “consumes a painstaking hour to accomplish much less profound results than are easily effected by the other [the vibrator] in a short five or ten minutes”. Electro-mechanical vibrators “mechanized speed and efficiency” and “improved clinical productivity” (Maines 1999: 11), in this sense extending the ‘limitations’ of clinicians (Boulter 2005). Reduced in-house costs, increased accessibility, and the employment of vibrators to treat a ‘disease’ that could never be ‘cured’ quickly became profitable for medicine (Maines 1999).

For Foucault (1978) hydrotherapeutic ‘cures’, vibrators and other massage technologies designed to ‘treat’ hysteria arose as a product of scientific and medical discourses that served to regulate and control society. Medicine “created an entire organic, functional or mental pathology arising out of ‘incomplete’ sexual practices; ....it undertook to manage them” (Foucault 1978: 41). The treatment of ‘hysteria’ through medical massage, hydrotherapy and vibrators served to regulate and manage (a)sexuality by writing it out of history (Foucault 1978). The possibility of desire (or ‘lack’ of) outside

of heterosexuality is erased through the medicalization of ‘hysteria’; the use of medical stimulation of the clitoris is not regarded as sexual because it exists outside of hetero-centric discourses which frame ‘proper’ sexuality as hetero-penetrative and reproductive (Downing, Morland and Sullivan 2015).

Through heteronormativity and medical discourses that frame hetero-penetrative sexuality as ‘proper’ sexuality, asexuality has come to be defined historically only through a ‘lack’ or ‘absence’ of sexual desires and practices. Asexuality therefore becomes something that must be confessed in order to be acknowledged as present, but if we consider asexuality’s absence as a “*meaning full*” (emphasis in original) presence in itself we open up possibilities to challenge Western hierarchies of relationships which privilege the sexual (Mazzei 2007: 29, Przybylo 2011). The absence of asexuality in traditional histories “bears ambiguous and therefore resistant potential” (Johnson 2011: 59). Rather than an ‘absence’ or ‘lack’, the notable silence of asexuality in traditional histories instead opens up space to transgress heteronormative understandings of attraction, desire, and sexuality itself. Using Derrida’s (1997: 6) understanding of “...the tension between memory...the preservation of something that has been given to us and, at the same time, heterogeneity, something absolutely new... a break” the silence of asexual histories can be considered as resistive and “*purpose full*” (emphasis in original) in its potential to disrupt gendered, heteronormative, sex-centric, Western society (Johnson 2011, Mazzei 2007: 29, Przybylo 2011).

## **2.2 Viagra**

Due to medicine privileging the body and physical aspects of sex over desire, attraction and emotion, sexual ‘dysfunctions’ were located in the anatomy. Medicalization locating sexual ‘dysfunction’ in the anatomy resulted in the development of a range of physical interventions, discussed in the previous subsection, in attempt to ‘cure’ or ‘fix’ these dysfunctions (Potts et al. 2004). In order to explore how the medicalization of sexuality persists to haunt contemporary Western society I turn now to discuss Viagra. Brooks (2001) comments on the continued attention afforded to develop methods to ‘improve’ male sexual performance, arguing, “medical science has relentlessly perused



an engineering solution to male sexual difficulties” (Brooks 2001: 54). In the following subsection I turn to examine how ‘medical treatments’ for sexual ‘dysfunction’ have shifted from techniques of “mechanical engineering” outlined in the previous subsection, to “chemical engineering” (Brooks 2001: 55) made readily available in contemporary society through the pharmaceutical industry.

Viagra has been largely documented as “the fastest selling drug in history” (McGinn 1988: 44). First approved in 1998, Viagra has been pervasively been framed as a ‘cure’ or ‘fix’ to erectile dysfunction, ‘sexual impotence’ and an absence of (hetero)sexual intercourse in relationships (Tiefer 2006). Marketing has framed Viagra as a drug that holds the ‘solution’ to personal and cultural ‘crises’ in masculinity, and has marked non-sexual relationships as unhappy, and failed (Vares and Braun 2006). Prior to Viagra, the onus to conform to ‘normative’ standards of heterosex had largely been placed on frigid women; men who were unable to sustain or achieve an erection had been positioned as simply ‘unable to perform’ (Loe 2004). However, the rise of feminist and sexual liberation movements (see further discussion in Chapter 4), alongside the increased availability of contraception resulted in a mounting male responsibility to successfully satisfy women (Loe 2004). In Western society ‘healthy’ or ‘successful’ masculine sexuality has been constructed around the idea that a “male body must be capable of producing ‘normal’ erections” (Potts et al. 2004: 490). ‘Normal’ erections are understood to be achievable ‘on demand’, and capable of satisfying “both the man and his (female) sexual partner” (Potts et al. 2004: 490), regardless of context. Medical research surrounding ‘sexual dysfunction’ was prominent both during the build up to and following the release of Viagra (Brooks 2001); Laumann’s paper explored the prevalence of ‘sexual dysfunction’ in the United States of America, and through interviews with participants surrounding their sexual experiences estimated that around a third of all men suffered from a form of ‘sexual dysfunction’, and concluded that this was an issue of “public health concern” (1999: NP). Laumann’s (1999) research, as well as multiple others (see the *National Health and Social Life Survey 1992*) received considerable media attention, and served to further fuel a ‘crisis’ of masculinity for men that perceived themselves as sexually dysfunctional as a result (Brooks 2001). Through this ‘crisis’ of masculinity, Viagra was able to present itself as a “tool capable of ‘fixing’ the broken male machine” (Loe 2004, Potts et al. 2004: 490). Tiefer (2006)

argues Viagra has transcended medical boundaries, and has become a cultural icon that continues to shape social norms and practices. An ‘absence’ or ‘lack’ of heterosexual performance has been constructed as emasculating through societally perpetuated narratives of masculinity that revolve around engagement in (hetero)penetrative sex (Potts et al. 2004). Viagra has transcended medical boundaries to be constructed as a ‘cure’ not only for a ‘medical problem’ but for personal, social and cultural ‘problems’ too (Tiefer 2006).

U.S. marketing campaigns for Viagra in the early 2000s portray distant and miserable looking couples contrasted with post-Viagra happy heterosexually active couples. Viagra’s marketing campaigns emphasize that everybody should want to engage in (hetero)penetrative sex, and that to not do so is to be isolated and unfulfilled (Vares and Braun 2006, Tiefer 2006). In using such campaigns Viagra advertisements compound the Western notion that normative sexuality is (hetero)penetrative. Ahmed (2010) argues that it is difficult to separate perceptions of happiness and ‘the good life’ from the heteronormative narratives that have been privileged historically. In Western society those who do not conform to (hetero)penetrative expectations have become marked as less valuable members of society through capitalist presumptions that to be happy is to be economically productive, and that to be happy necessarily involves being (hetero)sexually active (Ahmed 2010). Viagra’s marketing campaigns position asexuality or an absence of (hetero)sexual desire or engagement as synonymous with being unhappy and has further marginalized asexuality.

The (in)visibility of asexuality and an ‘absence’ of (hetero)sexual desire becomes further compounded when considering Bailey’s (1988) discussion of sex as a consumer object. Western society understands consumption as integral to constructing an individual identity; the “consumer is their own entrepreneur, [their] own producer of satisfaction and pleasure” (Chen 2013: 444). Foucault (2008) considers consumption as an entrepreneurial activity that transforms individuals into economic subjects; individual enterprise entities that uphold capitalist Western societies (Chen 2013). In capitalist Western societies to not consume sex is to be considered a bad economic subject; as not contributing to society through consumption (Bailey 1988, Lazzarato

2009). In Western society the worth of a subject is often measured in regards to their economic value (Lazzarato 2009). In this sense, the asexual is considered a bad economic subject as a result of framing sex as a consumer object (Bailey 1988), and through attributing individual worth on the grounds of economic value (Lazzarato 2009). Western society understands asexuality as a 'lack' or 'absence' of sexual desire, which also assumes a 'lack' of consumption, not just of sex, but also of pornography, sex aids or toys, and contraceptives. The notion of the bad economic subject can also be applied to the case study of Viagra; if a subject who experiences a 'lack' or 'absence' of (hetero)sexual desire then refuses to consume Viagra to 'fix' their lack of sexual consumption, their status as a bad economic subject is underlined by their double 'refusal' to consume. Capitalist models of consumption therefore position asexuality even further outside of normative sexuality in sex-centric Western society.

Genealogically I am interested in teasing apart the "apparent progressions of events, to fragment the cohesion" of dominant discourses surrounding Viagra, in order to trace how the medicalization of (a)sexuality became actualised, and the ways in which medicalization has further compounded asexual erasure (Hook 2005: 11). In the lead up to the production and marketing of Viagra's societal discourses had become increasingly medically essentialist (see further exploration in 2.1 pages 27-34), locating everything in the body (Loe 2004). Through medical essentialism social experiences become constructed as being either 'healthy' or 'sick'; common life events became understood as 'medical problems' (Tiefer 1994). Through the production and expansion of medical categories for sexual dysfunction Viagra was constructed as a consumer 'solution' to these 'problems'. Whilst Viagra is not chronologically the first example of the medicalization of (a)sexual practices (see discussion above in 2.1 pages 27-34), its popularity and significance was propagated through the circumstances and discourses surrounding its production. The neoliberal context in which Viagra was deployed produced subjects as 'individuals' and consumers whose societal value and worth was determined "by their capacity for 'self-care' – their ability to provide for their own needs" (Brown 2006: 694). Whilst surgical intervention necessarily involved the reliance of professionals to identify, 'provide' and 'care' for the subject's needs, Viagra could be self-administered, marking it apart from previously available examples of

(a)sexual medicalization such as vacuum pumps, erectile implants and surgical intervention (Baglia 2005). As a self-administered ‘cure’ Viagra was not only more accessible, but quicker; less time consuming for medical experts and patients alike, and for the ‘patient’ the desired result of “erections upon demand – a magic cure to sexual dysfunction” (Brooks 2001: 55) was more quickly attained (Baglia 2005).

At the same time as expanding medical categories and the rise of medically essentialist views, LGBT and sex positive feminist movements were raising the visibility of sexuality, suggesting different models of sexuality and promoting alternative sexual practices (Attwood 2009, Weeks 1989). The mainstreaming of sexuality, whilst further erasing asexual practices, rendered sexuality subject to increased control and regulation (Foucault 1978, Foucault 1995, Weeks 1989). Medical ‘advancement’ was equated to progress, where Viagra serves as a mode of regulation, designed to mould the subject into a more productive and valuable member of society (Foucault 1995, Loe 2004). Through the *National Health and Social Life Survey* of 1992 (Laumann et al. 1992) one yes/no question recorded over 40% of the population as sexually dysfunctional (through low or absent sexual arousal, desire or attraction); constructing sexual dysfunction or a ‘lack’ or ‘absence’ of (hetero)sexual desire as a ‘common problem’ (Conrad and Schneider 2010). Whilst constructing sexual dysfunction as ‘common’ the survey also constructs the absence of sex as a ‘problem’, presenting Viagra as the solution. Through constructing a ‘lack’ or ‘absence’ of (hetero)sexual desire as a problem, normative sexual function becomes unachievable without medical intervention and (a)sexuality becomes further marginalized (Loe 2004, Tiefer 2006).

Through the deconstruction of the multi-stranded and complex socio-political context in which Viagra was established, it is possible to critique the attendant historical climates and social constructs, to enable “an awareness of the complexity, contingency, and, fragility of historical forms” (Smart 1983: 76). Totalizing narratives that document sexual ‘dysfunction’ as requiring medical intervention in order to conform to a ‘healthy’ and ‘normative’ standard of sexuality (that remains forever unreachable) have been deconstructed to provide careful critique of the ways in which a ‘crisis’ in masculinity has been constructed. Tracing the socio-political contexts in which Viagra was

established as a cultural icon has illuminated the institutional mechanisms of power and regulation that facilitated the marketing of Viagra as ‘necessary’ and ‘progressive’.

### **2.3 Conclusion**

In conclusion to this chapter I have traced the medicalization of (a)sexuality in Western society through case studies that have explored the ‘treatments’ and ‘cures’ proposed to ‘fix’ an ‘absence’ or ‘lack’ of (hetero)sexual desire. I have explored how the rise of enlightenment thinking, in hand with technological advances or ‘scientific progress’, created new modes of governmentality and regulation, which served to further erase and marginalize asexuality within medicine. The treatment of ‘hysteria’ through medical massage, hydrotherapy and vibrators served to regulate and manage (a)sexuality by writing it out of history (Foucault 1978). Through case studies surrounding hysteria and frigidity and the ‘cures’ proposed to ‘treat’ them, I have identified the ways in which a ‘lack’ or ‘absence’ of (hetero)sexual desire was regulated and erased by medicine, which positioned treatments involving clitoral stimulation as ‘non-sexual’ due to them being outside of (hetero)penetrative and reproductive practices. This chapter then explored the shifts in ‘cures’ to a ‘lack’ or ‘absence’ of (hetero)sexual desire from “mechanical” solutions to “chemical engineering” (Brooks 2001: 55). Through tracing the production and marketing of Viagra, alongside the historical climates in which it was established, I argued that (hetero)normative narratives of ‘the good life’ (Ahmed 2010) have positioned anything outside of heterosexually active relationships as a failure. Paying attention to the construction of a ‘crisis’ in masculinity in Western capitalist societies that understand sex as a consumer object enabled an analysis of asexual’s as being positioned as ‘bad economic subjects’ (Bailey 1988, Lazzarato 2009). Measuring an individual’s worth against the economic contributions they make to a society has further marginalized both those who refuse to consume Viagra to ‘fix’ their ‘lack’ of (hetero)sexual activity and asexuality. The following chapter turns to address a further shift in understandings of a ‘lack’ or ‘absence’ of (hetero)sexual desire; from physiology to psychology.

### **3. Pathologization**

This chapter provides an exploration of the Pathologization assemblage, tracing the historic development of categorizations of ‘medical conditions’ which have rendered anything outside of (hetero)penetrative sexuality pathological. I examine the ways in which the pathologization assemblage has contributed to the maintenance of the invisibility and erasure of asexuality. I deconstruct historic medical and psychiatric collections, referring throughout to the socio-political contexts of each work, and the traces of (a)sexuality that run throughout. I first turn to the 19<sup>th</sup> century works of Krafft-Ebing (1886), as one of the first works to reference a ‘lack’ or ‘absence’ of sexual desire as a concern of science. Following the work of Krafft-Ebing (1886) I examine the works of Kinsey (1948, 1953) as one of the most significant contributions to works of sexology in the 20<sup>th</sup> century, before turning to pay significant attention to the Diagnostic and Statistical Manual (DSM) and its evolution in relation to the erasure and pathologization of traces of (a)sexuality. Throughout I explore the ways in which the affective invisibility of asexuality in the above works has shaped the landscape of more contemporary, and medically essentialist, conceptualisations of asexuality from Bogaert (2004, 2006).

The pathologization of (a)sexuality has contributed significantly to the maintenance of the social and cultural invisibility of asexuality, exploring the ways in which historic assemblages have constructed asexuality and associated practices seeks to enable a deconstructive critique of the ways in which stigmatizing and marginalizing discourses have been legitimized. Pathologization marks a shift in medicalization where attentions shifted from the body to the mind. The pathologization of previously ‘everyday problems’ enabled the implementation of a form of social control through the disciplinary technology of listening, synonymously to Foucault’s (1989) medical gaze (Hook 2010). The pathologization of the psyche is a relatively recent construct, as Foucault (1989) highlights through tracing the historical construction of ‘mental illness’. Prior to the industrialisation of the 17<sup>th</sup> century madness was embraced as an inherent part of human subjectivity, but during the 18<sup>th</sup> century ‘madness’ became considered as problematic and in need of ‘cure’. From the 18<sup>th</sup> century institutions arose around the West in order to house those considered ‘mentally ill’ or ‘insane’ away from

the rest of society (Foucault 1989). It is within these institutions where Krafft-Ebing (1886) conducted his work, and it is also from such institutions where Kinsey (1948, 1953) recruited his participants. I turn now to my case studies in order to further map the ways in which the pathologization assemblage has contributed to the (in)visibility of asexuality.

### **3.1 Krafft-Ebing: *Asexuality and Sexual Anaesthesia***

Krafft-Ebing's (1886) 19<sup>th</sup> century work was one of the first to begin the structural reordering of sexual behaviours previously concerns of law, judicial practice, religion or morality, into the realm of medicine. Krafft-Ebing's (1886) works were developed during a period of significant shifts in the ways in which the world was understood. Rose (1997: 242) considers the "argument that psy has taken the place of religion" as too simplistic, rather I understand religion as persisting to haunt the works of psychiatry and medicine. However, the declining significance of religion in the 19<sup>th</sup> century alongside enlightenment thinking and the rise of Darwinism promoted biological essentialism and a 'survival of the fittest' mentality, where continual 'improvement' was seen as key to the continuation of civilization. Traces of religious concern for the morality of sexuality remain in Krafft-Ebing's (1886) works though: 'proper' sexuality was considered hetero-penetrative, and the aim of any sexual behaviour for Krafft-Ebing should always and only be procreation; "everything except penetrative heterosexual intercourse would logically come under suspicion as abnormal or *contra nature*" (1886: 45). Marriage was deemed the "only appropriate domain for sexual expression" (Downing, Morland and Sullivan 2015: 47) and sexuality was still seen as a moral project that should be worked on, aspired towards, and should be achieved for the sake of civilization (Krafft-Ebing 1886). The works of Krafft-Ebing (1886) enabled the repackaging of the morality of sexuality that had been the concern of religion for so long, as belonging to the domain of the science.

Krafft-Ebing was a German born psychiatrist, and is regarded as making one of the most significant contributions to the study of psycho-sexology (Oosterhuis 2000). The publication of *Psychopathic Sexualis* cemented him as a high profile, if controversial figure at the time. Krafft-Ebing (1886) worked closely with Freud, despite disagreeing with him on many counts, including Freud's seduction theory, which Krafft-Ebing

openly dismissed as a “scientific fairy tale” (Oosterhuis 2000: 88). Krafft-Ebing (1886) ‘branded’ his practice of psychiatry as for the upper-middle-classes who sought to escape asylums or mental institutions. Prior to Krafft-Ebing’s (1886) work sexual ‘dysfunction’ was either dismissed as insanity or treated as a religious matter, but the rise of biological essentialism created a discursive context where Krafft-Ebing’s work was taken up quite significantly (Oosterhuis 2000).

Krafft-Ebing’s (1886) work highlights the convergence of science and religion at the turn of the century; he opens his work with the assertion that the continuation of humanity is “guaranteed by the hidden laws of nature which are enforced by a mighty, irresistible impulse” (1886: 1). The propagation of procreation as an innate and essential characteristic of normative humanity follows intellectual trends in thinking promoted by the rise of Darwin’s (1859) works and enlightenment thinking. Krafft-Ebing (1886) positions sexuality as something beyond the agency of an individual, that cannot be contained in any way, and is ultimately controlled by ‘nature’. In doing so the works of Krafft-Ebing (1886) position anything outside of pro-creative heterosexual desire, behaviour or attraction, as deviant, unnatural and abnormal. Flore (2015: 19) summarises Krafft-Ebing’s (1886) works as concluding that “life consisted of two primary instincts: self-preservation and sexuality”. Framing sexuality as innate, universal and the key to survival of civilization enabled the production of the ‘need’ to regulate sexual desire; Krafft-Ebing’s (1886) works catalogued and judged sexual characteristics from an “evolutionary perspective” (Kim 2015: 256). In tying sexuality to the survival of a species “the direction of one’s sexuality is made central to identity” (Flore 2015: 19) because to not participate in pro-creative sexual practices becomes not only sexually deviant, but also socially abnormal.

Krafft-Ebing’s (1886) *Psychopathia Sexualis* contains numerous categories of sexual ‘deviance’ and social ‘abnormalities’, but for the purposes of this genealogy I will be paying particular attention to the traces of contemporary (a)sexuality present within the categorisations of *asexuality* and *anaesthesia sexualis*. The term *asexuality* is used within *Psychopathia Sexualis* (Krafft-Ebing 1886) to categorise those who have been physically castrated before puberty. The ‘absence’ or ‘lack’ of sexual desire as a



consequence of genital castration before puberty is entirely permissible for Krafft-Ebing (1886). The argument that *asexuality* was a result of genital castration prior to puberty enabled Krafft-Ebing (1886) to argue that there was a “connection between genital glands, developmental phases, and sexual instinct” (Kim 2015: 256). In asserting sexual desire, attraction and behaviour are reliant on a ‘healthy’ and ‘functioning’ body, specifically the genitals; Krafft-Ebing (1886) also underlines discourses of biological essentialism that locates sexuality as a product of biology. *Asexuality* therefore becomes positioned as pathology of the body, something that is fixed, finite and preclusive of all other gendered or sexual identities. Krafft-Ebing’s (1886: 45) focus on the importance and ‘natural’-ness of procreation therefore positions those who are unable, unwilling or do not choose to reproduce, as ‘abnormal’ and “*contra nature*” but also as endangering the survival of the species.

Krafft-Ebing’s (1886) definition of *asexuality* contains traces of contemporary understandings, but frames it in such a way that it remains a ‘problem’. The notion that (heterosexually) functioning genitals are key to normative sexual desire positions those who experience low sexual desire with no genital ‘abnormalities’ even further from normative sexuality. Through biologically essentialist and naturalist assumptions present in Krafft-Ebing’s (1886) works sexuality becomes rooted in the body, positioning ‘healthy’ levels of sexual desire and response as reliant on a ‘functioning body’, with disregard to identity, desire or emotion. Krafft-Ebing’s (1886) *asexuality* haunts contemporary discourses of sexuality, where genitals and sexuality are commonly conflated, confused or taken to be indicative of one another. Butler (1990: 175) argues that identity is inherently disturbed by a state of constant becoming, but that “‘coherence’ and ‘continuity’ of ‘the person’ are not logical or analytic features of personhood, but, rather, socially instituted and maintained norms of intelligibility”. Using Butler’s (1990) work on intelligibility the conflation of genitals and sexuality can be understood as symptomatic of a society in which hetero-sex is privileged, because in order for heteronormativity to persist certain identities must not ‘exist’. Krafft-Ebing’s (1886) definition of *asexuality* also contains traces of sex-centric Western society’s assumption that sexual desire is innate and ‘natural’, except in bodies that appear to function ‘abnormally’. Contemporary understandings of sexuality are shaped and

produced through historical categorizations, which in turn have been shaped through the context in which they were developed (Cvetkovich 2003, Foucault 2003). There is a common assumption in contemporary Western society that those whose bodies do not conform to Western ideological standards of beauty, including those regarded as disabled, perceived to be trans, the elderly or the young, should not or do not engage in sexual acts or experience sexual desire (Kim 2015). The assumption that these bodies are not desirable and therefore should not be desired brings with it the supposition that ‘undesirable’ individuals do not experience their own desires (Kim 2011). McRuer and Mollow (2012: 24) comment, “disability and sex... often threaten to unravel each other”. We can read Krafft-Ebing’s (1886) *asexuality* as a “buried historical trauma” that has become an affective form of invisibility of “everyday emotional life” (Cvetkovich 2003: 6). In Western ableist society, sex is considered reliant on a ‘fully functioning’ body; if disability is present, by ableist logic, sex cannot be (McRuer and Mollow 2012). Krafft-Ebing’s (1886) *asexuality* follows ableist lines of thinking that render ‘normative’ sexuality reliant on ‘normative’ bodies (Kim 2011, McRuer and Mollow 2012).

Contemporary understandings of asexuality are perhaps more closely relatable to what Krafft-Ebing (1886) terms *anaesthesia sexualis*. Krafft-Ebing’s (1886) work separates *asexuality* (perceived to be an inhibition of the body), from *anaesthesia sexualis*, literally translated to the ‘absence of sexual feeling’. Krafft-Ebing (1886) coins the term ‘sexual anaesthesia’ in relation to several case studies he includes of ‘patients’ who report experiencing little or no sexual desire. Traces of Krafft-Ebing’s (1886) are present within the previously discussed contemporary example of *House: Better Half* (2012) (see page 23 in Chapter 2), where House claimed, “the only people who don’t want sex are either sick, dead or lying”. The passivity implied in Krafft-Ebing’s (1886) categorization of ‘sexual anaesthesia’ denotes docility and a lack of agency, in the same way that House’s claim that to not want sex renders you “dead” (*House: Better Half* 2012). Employing the term anaesthesia removes the agency of the patient, turning them into an inert body and an object of medical observation (Foucault 1989).

*Psychopathia Sexualis* includes case studies of a range of ‘patients’ who presented themselves to Krafft-Ebing (1886: 40-41) describing experiences of “no erotic inclination”, an “absence of sexual instinct”, or who had “rarely enjoyed sex”. “Case 3” referred to as “K” is described as claiming “never to have experienced a sensual emotion”, Krafft-Ebing (1886: 41) comments:

“K., age 29, civil servant, consulted me on account of his abnormal condition... Sexual life was known to him only from what he had heard other men say about it or from what he had read in erotic novels, which, however, had never made any impression upon him. He had no dislike for the opposite sex, or special inclination towards his own sex, and had never masturbated...excepting this want of sexual instinct K. considered himself to be quite normal. No physical defects could be detected. He was fond of solitude, but of a frigid nature, without interest in the arts or the beautiful, but a highly efficient and esteemed individual”.

Krafft-Ebing’s (1886) assessment of K. ignores K’s lived experience of life without sex, instead focusing on the ‘lack’ of “sexual instinct” as problematic, pathological and something that warranted medical or psychiatric investigation. Krafft-Ebing (1886: 41) describes K. as being of a “frigid nature”, a phrase typically associated with women, suggesting K’s ‘lack’ of interest in sex has resulted in Krafft-Ebing (1886) gendering K. differently, coding K’s behaviour as female or feminine. Psychiatric case studies encapsulate Foucauldian (1990) understandings of the confession, whereby the “agency of domination does not reside in the one who speaks (for it is he who is constrained), but in the one who listens” (1990: 62). However, patient K’s confession is that he is “quite normal” (Krafft-Ebing 1886: 41). As with asexuality in contemporary society, K. must disclose details of his non-sexual behaviours so that Krafft-Ebing (1886) can access the ‘absence’ and categorize him accordingly. Hook (2010: 35) notes that through confession ‘the medical gaze’ transcends the borders of psychiatry through the “disciplinary technology of listening”. It is through the “disciplinary technology of listening” that Krafft-Ebing (1886) diminishes patient K. to a series of ‘symptoms’, eventually summarising his entire being in one reductive paragraph.

A second 'Patient' W. is recorded by Krafft-Ebing (1886: 41) as:

“age 25, merchant, claimed to be untainted, never had a severe illness, never had masturbated, since his nineteenth year had but rarely pollutions, mostly without sensual dreams. Since his twenty first year *coitus rarissimus, actus quasi masturbatorious, in corpore feminae, sine ulla voluptate*. W. declared to have made these attempts solely through curiosity, and soon gave them up all together as desire, gratification, and ultimately even erection were wanting. He never had any leaning towards his own sex. His deficiency did not seem to cause him any worry. In the ethical and aesthetical field there were no abnormal manifestations.”

The assessment of W. positions him as 'deficient' due to his low interest levels in sexual practices despite the patients own lack of concern in regards to his levels of sexual desire. Krafft-Ebing (1886: 41) remarks the patient's levels of sexual desire “did not seem to cause him any worry”, making the patient's lack of concern noteworthy and thus abnormal. Krafft-Ebing (1886: 41) then goes on to remark that “there were no abnormal manifestations” ethically or physically, as if the presence of 'abnormal' physical or ethical 'conditions' would adequately justify the patient's experience of sexual desire.

The attention paid to the 'lack' of physical 'abnormalities' reduces sexual desire to something that is biologically or morally determined. Krafft-Ebing's (1886) concern with physiological, psychological and medical health in the patient can be tied back to the rise of biological essentialism and traces of religion present within his works. Krafft-Ebing (1886) notes that patients are physically 'normal' despite appearing to privilege their emotion over their physical responses in his notes; the sentence “desire, gratification, and ultimately even erection were wanting” (1886: 41) implies that Krafft-Ebing is more concerned with the patients' 'lack' of sexual desire, rather than their lack of physical arousal, making desire and gratification a prerequisite for erection. Despite the patients' lack of concern at their 'symptoms', Krafft-Ebing (1886) deems them

worthy of examination and investigation. Krafft-Ebing (1886) notes that masturbation was rare and without desire towards the body of the woman. Given the time of Krafft-Ebing's (1886) work, to record this observation as 'abnormal' was controversial given the large quantity of medical literature and 'cures' proposed to treat masturbation (see Brodie 1845).

As an aside, the dual construct of the pathologies of an 'absence' of masturbation alongside the wider social and cultural prohibitions of masturbation highlights the impossibility of sexual 'norms'. To masturbate was considered to lead to impotence, destroy "the germ of manhood" (Brodie 1845: 10) and be an "impediment to procreation" (1845: 33); the only form of sex deemed non-pathological during the 18<sup>th</sup> Century. However, Krafft-Ebing's (1886) case study of patient W. highlights that not masturbating was also considered problematic, putting the subject in a double bind of either being categorized as 'suffering' from *Anesthesia Sexualis* or being considered impotent and have "an incapacity for entering into the marriage state" (Brodie 1845: 12).

The inclusion of instances of "rarely enjoy[ing] sex" in works which address sexual pathologies implies that "rarely" (or never) enjoying sex is problematic, and something that warrants remedy or cure (Krafft-Ebing 1886: 41). Foucault's (1989) 'medical gaze' enables Krafft-Ebing (1886) to ignore the individual differences of identity and life experience (absently) present within patients K and W, instead perceiving them as sets of pathological symptoms and categorizing them as 'suffering' from "*anaesthesia sexualis*". However, Krafft-Ebing (1886) argues the experiences categorized as 'sexual anaesthesia' are completely 'natural' in both children and elder adults; sexual desire in the elderly or young also becomes pathologized, and is referred to as *paradoxia*. Here, Krafft-Ebing's (1886) work sits in contradiction to Freud (1975) who understood sexuality as a normative part of children's social and psychological development. However, in Krafft-Ebing's (1886) work whilst sexuality is constructed as 'natural', an 'impulse', and moral obligation, it is 'natural' only within hetero-penetrative frameworks that facilitate reproduction.

The reduction of instances of (a)sexuality or any sexual experience that transgresses hetero-sex-centric narratives to a series of symptoms that are framed as pathological persists to haunt contemporary conceptualisations of (a)sexuality, merging “the visible and the invisible, the tangible and the ungraspable, creating the particular form of affective sociality of living with ghosts” (Gordon 1997: 195). Black (2011) uses the work of Gordon (1997) to argue that prisoners are ‘living ghosts’ presided over by legal institutions and disciplinary power structures that have rendered them part of a haunted category. The affect of psychiatry can be viewed as acting synonymously on sexualities that exist outside of the normative model of hetero-penetrative, procreative sex. Through psychiatry (a)sexuality becomes a prisoner of the body, heteronormative institutions, histories, and disciplinary technologies that have silenced anything outside of hetero-sex (Black 2011, Foucault 1977). Black (2011: 8) argues for the acknowledgment of haunting as a relation and resource for hope that is alive through repression and situations of “unfreedom”. Black’s (2011) interpretations of Gordon (1997) enables a re-presentation of the silencing of (a)sexual experiences through psychiatry. (A)sexual histories do not become understood as ‘lacking’ or ‘absent’ but can instead be reconceptualised as transformative and “connected to a situation in the present as it moves towards the future” (Black 2011: 8). Following the above exploration of Krafft-Ebing’s (1886) late 19<sup>th</sup> century work, I now turn to assess Kinsey’s (1948, 1953) research as one of the most significant contributions to sexology in the 20<sup>th</sup> century.

### **3.2 Kinsey’s ‘X’**

In the following subsection I now turn to examine Kinsey’s (1948, 1953) research on human sexual behaviour. Kinsey’s (1948, 1953) work was part of a 20<sup>th</sup> century trend in behaviourism, in which behaviour became privileged over identity, emotion and other forms of expression. Behaviourism encouraged psychology and other psycho-medical practices to concern themselves with that which they could observe, and marked a major shift in intellectual thinking within the field. The Kinsey Reports (1948, 1953) were a product of this shift to behaviourism within the field of psychology. Kinsey’s (1948, 1953) works gathered data from a huge number of participants, all of whom were white American. Data was collected (according to The Kinsey Institute 2015) through in

depth interviews, where up to 516 questions about sexual history and behaviour were asked to participants. The emphasis on sexual behaviour disregarded emotion, fantasy, or any factor outside of physiology as a direct response to rising trends in behaviourism at the time, sitting in contrast to Krafft-Ebings (1886) implied privileging of desire over physical response (see pages 41-48 in the previous subsection). There have been a number of public criticisms of the Kinsey Reports (1948, 1953) ranging from allegations of biased sampling to those of rape and paedophilia occurring under Kinsey's supervision (see Jones 1997, Reisman 1990). Reisman's (1990) criticism of Kinsey has become a lifelong work, with her establishing an 'Anti-Kinsey Movement' as a direct result. The majority of Reisman's (1990) criticisms focus on undermining Kinsey's conclusions, which sought to establish homosexuality as 'natural' rather than the ethical problems of Kinsey's (1948, 1953) works, and are notably supported by the Christian *Salvo* magazine, a conservative Christian U.S. based magazine.

As with Krafft-Ebing (1886), Kinsey's (1948, 1953) works were introduced as being of service to the medical profession; the framing of Kinsey's work as 'scientific' and integral to medical advancement permitted Kinsey (1948, 1953) to investigate previously taboo topics, under the pretence of their necessity to scientific development (Nardi 1998).

Kinsey (1948, 1953) considered sexuality to be fluid, and plotted a seven-point scale to visualise this, with heterosexuality plotted with a value of 0 and homosexuality plotted with a value of 6. Kinsey's (1948, 1953) scale constructed homosexuality and heterosexuality as innately opposite, despite acknowledging they were changeable and not preclusive of each other. Kinsey's (1948, 1953) participants were assigned a number on the scale on the basis of their sexual activity. The value of 0 was assigned to those who recounted exclusively heterosexual responses, 1 to those who recalled 'only incidentally' homosexual responses, 2 to those who confirmed 'more than incidental' homosexual behaviours, 3 to those who Kinsey (1948, 1953) deemed to show 'equally' heterosexual and homosexual responses, 4 to those who responded with 'more than incidental' heterosexual behaviours, 5 to those who Kinsey deemed exhibited 'only incidentally' heterosexual responses, and 6 to those who Kinsey defined as

‘exclusively’ homosexual. The use of the word ‘incidental’ suggests that Kinsey (1948, 1953) thought of sexuality in terms of discrete acts, or ‘incidents’, and emphasises his privileging of behaviour over identity or desires. Kinsey (1948, 1953) gave the value of ‘X’ to those who he deemed to have recalled an ‘absence’ of sexual response. ‘X’ participants remained un-plotted on the Kinsey scale (See Fig. 2), reiterating the medical opinion that a ‘lack’ of sexual response is a problem, and for Kinsey (1948, 1953) outside of ‘normative’ sexuality.

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Figure 2. Kinsey Scale (Hille 2014)

There is no account of what Kinsey (1948, 1953) understood to be heterosexual or homosexual stimuli, although it has been suggested by a number of sources (see Jones 1997, Reisman 1990) that stimuli may have included pornography or explicit sexual contact with researchers. Kinsey described ‘X’ participants as those who did “not respond erotically to either heterosexual or homosexual stimuli” (Kinsey 1953: 472). Whilst participants categorized as ‘X’, who did not respond to this ‘stimuli’, were not recorded on the ‘Kinsey Scale’ (See Fig. 2), they did feature in Kinsey’s (1948, 1953) tables of results (See Fig. 3). Participants categorized as ‘X’ were given little mention in Kinsey’s (1948, 1953) analysis or discussion of results, and were regarded as *needing further research*, as an ‘anomaly’. The value of ‘X’ was assigned by Kinsey (1948, 1953) on the basis of their accounts of (or researchers accounts of) physical response or behaviour: neglecting participants identity, attractions and desires.



Przybylo (2012: 227) argues that Kinsey's (1948, 1953) works "did not provide asexuality with any real territory", and so places it outside the assemblages which could otherwise territorialize bodies', variously restricting and enabling what a body can do or become. But asexuality does move through the assemblage (Deleuze 1987, Fox 2012). I argue that asexuality moves through assemblages of medicalization, pathologization and politicization as a trace of a node, with an agency of its own. We can understand Kinsey's (1948, 1953) reports as containing traces of (a)sexuality that both restrict the shape of it, through the exclusion of X participants from the 'Kinsey Scale', and open up possibilities of asexuality, through 'X' participants acknowledgement in Kinsey's (1948, 1953) tables of results. There is territory here, if one shaped by uncertainty - *needing further research* - and, ultimately, absence. The absence of participants categorized as 'X' in the 'Kinsey Scale' (See Fig. 2) means Kinsey (1948, 1953) fails to give asexuality any legitimacy, and locates asexuality as outside of normative sexuality.

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Figure 3. Kinsey 'Summary and Comparisons' Table (Kinsey 1953: 488)

Kinsey (1948, 1953) argues towards an understanding of sexuality as fluid, a concept that had previously remained unspeakable due to Western discourses of sexuality that were heavily influenced by religion and biological essentialism. However, Kinsey's

(1948, 1953) persistent argument that sexuality should be considered fluid still understood sexual attraction and desire as inherent. For Frers (2013: 433) the presence of sexual fluidity in Kinsey's (1948, 1953) works would highlight that the "presence...can only be a failure, a gap" (Frers 2013: 433). By excluding participants given a value of 'X' from the Kinsey scale (See Fig. 2) it is suggested that (a)sexuality, or 'X' participants, cannot be fluid, that there is no space for sexual fluidity when an 'absence' or 'lack' of sexual desire is present. Kinsey (1948, 1953) thereby ignores any possibility of sexuality outside of physical response or interaction and confines sexuality to sexual practice, as well as discounting the experiences of participants labelled 'X'.

Analysing Kinsey's (1948, 1953) works using Derrida's (1993) notion of the trace, it can be argued that the negligence of 'X' participants, and the absence of discussion around their presence, could be seen as a strategic response to societal discourses. Derrida's (1993, 1976) work argued that silence could be seen as a strategic response to discourses. As Kinsey's (1948, 1953) research attempted to confront persistent Western discourses of homosexuality as pathological, as well as Western assumptions that females had inherently lower sexual responses, ignoring participants who challenged Kinsey's (1948, 1953) ideas can be read as a strategic response by Kinsey to socio-political discourses at the time (Derrida 1993, Przybylo 2012). In order for Kinsey (1948, 1953) to advance his agenda to 'prove' homosexuality to be 'natural' and to demonstrate the existence of female sexual desire, Kinsey (1948, 1953) sidelined the high frequency of female 'X' participants, as they did not support his argument. Downing, Morland and Sullivan (2015) detail Western understandings of sexuality in the 19<sup>th</sup> century as heavily influenced by religion, and thus a moral project (see page 24 on the rise of enlightenment thinking). In response to discourses of sexuality as a moral project that should be worked on in order to be a good Christian subject, Kinsey (1948, 1953) attempts to position sexuality both as fluid and as innate or 'natural', something that should be embraced rather than 'worked on'. We can therefore understand Kinsey's (1948, 1953) erasure of participants given a value of 'X' as a strategic response to socio-cultural discourses shaped by enlightenment thinking and behaviourism; generating culturally specific sexual knowledges (Derrida 1993, Fox and Alldred 2013).

In the following subsection I will explore how the historic erasure of (a)sexuality from the pathologization assemblage has continued to haunt contemporary psychiatric discourse through the Diagnostic and Statistical Manual.

### **3.3 The Diagnostic and Statistical Manual**

In order to explore how the historic pathologization of (a)sexuality continues to haunt contemporary lived experiences, I now turn to the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM has come to be a legitimate discourse, which large portions of Western society subscribe to. As a result, the ways the DSM addresses asexuality has a significant impact on its visibility and how contemporary asexuality is shaped. I further explore the evolution of diagnostic criteria and categories of ‘sexual disorders’ to provide an account of how the pathologization of asexuality can be traced historically. I deconstruct the emergence of diagnostic criteria in the DSM, following Dauenhauer’s (1980: 119) call to reconceptualise what is “seen, heard, and read”, in order to “listen” to the resistance of silent discourses.

The DSM has been established as a definitive institutional discourse since the 1950’s. Originally developed in the aftermath of World War II out of the U.S. military classification scheme ‘Medical 203’, the DSM was created to provide a unifying list of psychological diagnoses in the wake of several differing systems of classification. The DSM has been constructed through the dominant discourses of the late 19<sup>th</sup> and 20<sup>th</sup> centuries that proliferated narratives of science, enlightenment and reason as ‘progress’. Advances in technology throughout the 20<sup>th</sup> century led to ‘progress’ being defined as scientific. The DSM was established during the same decade as the development of the atomic bomb, the space race and the first computer, and through its affiliation with science and biomedicine the DSM came to exercise authority and influence over “*what counts* – what gets recognized and legitimized – as ‘healthy’ and ‘normal’” (Potts 2002: 15). Through the unification of diagnostic criteria and categorization of psychological ‘disorders’ the DSM intended to create a universal field of language to communicate within the discipline of psychiatric medicine. However, the DSM has been repeatedly revised since its first publication in a continued attempt to resolve discrepancies in interpretation and is currently in its 5<sup>th</sup> edition. The DSM serves to categorize and

pathologize Western populations, resulting in a self-regulatory society that is more easily managed (Foucault 1989).

For Foucault (1978: 116) medical and psychiatric models were directed towards “frauds against procreation”, or anyone that did not pursue hetero-penetrative and monogamous sexuality, and were purposed to “protect morality” (Flore 2014: 42). Foucault (1978: 31) argues that the construction of sexual dysfunctions as pathological has “radiated discourses aimed at sex, intensifying people’s awareness of it as a constant danger”.

The DSM serves to enable the institutionalization of self-regulation, through extensive categorization and what Foucault (1989) dubs ‘the medical gaze’. For example current diagnostic criteria and treatment guidelines for ‘Gender Dysphoria’ ensures the self-regulation of trans identified individuals and the maintenance of the gender binary through diagnostic criteria which calls for a ‘marked difference’ to be present between an individuals ‘expressed’ gender and their gender assigned at birth. In doing so the DSM paved the way for treatment criteria that asserts individuals must demonstrate they are capable of sustaining social and economic ‘functionality’ in their chosen gender before accessing ‘medical’ treatment plans. In the Western context there is a continued assertion that trans ‘patients’ cannot undertake any form of body modification without psychiatric approval and adequate evidence that they are both working and socialising at a ‘required’ level.

Diagnostic criteria and requirements for treatment ensure a self-regulatory patient body. In order to access ‘treatment’ individuals must fulfil a certain number of diagnostic criteria, and demonstrate the eligibility for diagnosis, and in turn treatment, in a way that is predefined by the DSM. For Foucault (1977: 136) therefore the self-regulation enabled through the DSM serves to mould subjects “out of a formless clay” into more economically valuable, “more obedient” and “more useful” subjects in order to propagate a self-sustaining society, requiring less time and resources to manage itself. In the case of ‘Gender Dysphoria’ the DSM’s diagnostic criteria and the treatment criteria that evolve from them ensure the preservation of the gender binary, normative gender roles and patriarchal structures in Western society. The DSM reduces people to a

series of symptoms, systematically ignoring individual agency and the multiplicity of identity; progressively eliminating social deviancy. The DSM therefore both produces and is produced by socio-cultural discourses, constructing the 'patient' as devoid of agency and pathological (Foucault 1989). The disregard of difference in social, psychological, or physical identity in the DSM is problematic for Butler (1993), who argues identities continually fail because we are continually undone by both ourselves and others.

By providing an ever-increasing list of psychiatric, sexual or social 'dysfunctions', the DSM constructs the most mundane of human experiences as pathological, and imposes limits on 'appropriate' sexuality (Fox and Alldred 2013). From a Deleuzian (1987) perspective, the DSM serves as a point within an assemblage, which directs "the [sexual] capacities produced in bodies" (Fox and Alldred 2013: 770). The pathologization assemblage territorializes a body's desires, simultaneously restricting the shape of sexuality, as well as rendering it infinitely varied (Fox and Alldred 2013). The ever-increasing list of sexual 'dysfunctions' within the DSM both increasingly limits what 'normative' sexuality can be understood to be, and simultaneously creates numerous possibilities for legitimate forms of sexual expression (albeit 'disordered'). For example, the DSM V (American Psychiatric Association 2013: 433) recommends a diagnosis of Female Sexual Interest/Arousal Disorder if an individual has "little interest in sex", "few thoughts relating to sex", "decreased start and rejecting of sex", "little pleasure during sex most of the time", "decreased interest in sex even when exposed to erotic stimuli" or "little genital sensations during sex most of the time". The diagnostic criteria both legitimizes a 'lack' of interest in sex for women, and reterritorializes the experience as a disorder in need of a 'cure'. For Thrift (2004: 61) because within assemblages each part has the capacity both to affect and be affected, territorialisation and reterritorialisation create a state of perpetual "becoming".

Through diagnoses of 'sexual disorders' the DSM has enforced the essentialist notions that sexual desire and attraction are innate and 'natural'. The DSM has been of huge significance in propagating the pervasive stigmatization and pathologization of those who don't experience sexual desire, experience low levels of sexual desire, or

experience sexual desire in non-‘normative’ ways. For example, the American Psychiatric Association classified homosexuality as a ‘sexual disorder’ and thus ‘mental illness’ until 1973 (Bayer 1987). Through the DSMs framing of ‘normative’ sexuality as hetero-penetrative, those engaging in non-‘normative’ sexual practices, or not engaging in sex at all, are implied to be less valuable and worthy members of society (Flore 2014: 45).

Traces of (a)sexuality have been present in the DSM since its first edition, but the DSM III was the first edition where ‘symptoms’ that could be likened to contemporary asexuality were presented as an entirely separate disorder; ‘Inhibited Sexual Desire’ within the ‘Psychosexual Disorders’ subsection (American Psychiatric Association 1980, Hinderliter 2015). The DSM III was compiled during a period of significant criticism of psychiatry more broadly (Angel 2012). Work from the Anti-Psychiatry Movement (See Laing (1964, 1960) and Goffman (1961)) was gaining attention and being taken up more widely in popular discourse, and there were substantial concerns raised around the amount of space left for interpretation in DSM diagnostic criteria, that had led to allegations of multiple discrepancies in diagnoses between psychiatric practitioners (Angel 2012). As a result of these criticisms there was a conscious effort to provide more quantifiable diagnostic criteria in the DSM III and attempted to root diagnosis in ‘medically observable’ or biological and physiological terms as opposed to the psyche (Angel 2012). Despite their attempts to provide clearer diagnostic criteria in the DSM III, they remained suitably vague for ‘Inhibited Sexual Desire Disorder’ requiring the practitioner use their own judgement about how factors including the patients’ age, circumstances and lifestyle may influence their behaviour or feelings before issuing a diagnosis (Morrison and Bellack 1987). The only requirement given was that the individual had a “persistent global inhibition of sexual desire” (Morrison and Bellack 1987: 97). Morrison and Bellack (1987) indicate that treatments for ‘Inhibited Sexual Desire Disorder’ at the time may have included low doses of testosterone, however treatments are not discussed at all in the vast majority of related literature. Kaplan (1979) suggested that the response to treatment was substantially poorer in cases of ‘Inhibited Sexual Desire’ than it was in treatments for ‘Inhibited

Orgasm’, but does not reflect on why she felt ‘Inhibited Sexual Desire’ was necessary to treat, or why these differences in effectiveness might be present.

In the DSM III-R (the revised version of the DSM III) ‘Inhibited Sexual Desire’ was reclassified as ‘Sexual Desire Disorders’ and divided into ‘Sexual Aversion Disorder’ for men and ‘Female Sexual Arousal Disorder’ for women, due to concerns that ‘Inhibited Sexual Desire’ gave the impression of psychodynamic aetiology that was under critique at the time (American Psychiatric Association 1987, Hinderliter 2015). The overarching category of ‘Psychosexual Dysfunctions’ was also replaced with ‘Sexual Dysfunctions’ in order to continue to distance the DSM from the on-going controversy in regards to psychiatry and psychoanalysis. The gendered diagnoses present within the DSM III-R uphold hegemonic standards of masculinity through their gendered categorizations. ‘Female Sexual Arousal Disorder’ implies that it is not possible for men to ‘lack’ sexual arousal, instead positioning a ‘lack’ of sexual desire for men as ‘Sexual Aversion Disorder’. These categorizations assume an innate sexual desire in men, and that any decision or inability to fulfil these desires must be as a result of an ‘aversion’ to sex, rather than a lack of interest or arousal, again placing asexuality under erasure.

In the DSM IV the diagnostic criteria shifted again for both ‘Sexual Aversion Disorder’ and ‘Female Sexual Arousal Disorder’, so that ‘patients’ must experience direct “distress or interpersonal difficulty” as a result of a ‘lack’ of sexual desire (American Psychiatric Association 1994: NP). The publication of the DSM IV coincided with the accidental discovery that Sildenafil could evoke penile erections; Sildenafil went on to be marketed by Pfizer as Viagra (see pages 34-39 for further discussion of Viagra) and to be prescribed to treat erectile dysfunction. By maintaining the gendered separation of categorizations Viagra’s gendered audience was already predefined by the DSM IV.

The most recent edition of the DSM (DSM V), still features gender divisive diagnoses, ‘Female Sexual Arousal Disorder’ (FSAD) remains for women, but ‘Sexual Aversion Disorder’ has been re-categorized as ‘Hypo-active Sexual Desire Disorder’ (HSDD) for men (American Psychiatric Association 2013, Brotto 2010). Both diagnoses share

considerable similarities with definitions of asexuality given by the *Asexual Visibility and Education Network*, an online community of self-identified asexuals (the *Asexual Visibility and Education Network* is discussed in more depth in Chapter 4). Diagnostic criteria for each disorder have been altered to include a sub-clause exempting self-defined asexuals from diagnosis (Brotto 2010). The amended diagnostic criteria indicate that a diagnosis of either disorder should not be made if the individual acknowledges that a “lifelong” lack of sexual desire is “better explained by one’s self-identification as ‘asexual’” (American Psychiatric Association 2013: 434). Through the addition of a disclaimer that prevents a diagnosis of HSDD or FSIAD if the individual identifies as asexual, asexuality becomes something to be confessed, in order for society and the clinician to measure the extent to which that ‘patient’ is ‘truly’ asexual. Foucault (1960: 65) summarises that the “agency of domination does not reside in the one who speaks (for it is he who is constrained), but in the one who listens and says nothing”. For Hook (2010) it is through psychiatrist and the notion of the ‘confession’ that listening becomes a disciplinary technology, functioning synonymously with Foucault’s (1989) ‘medical gaze’, to reduce the patient to a series of symptoms or pathologies. Despite the impossibility of measuring desire, the DSM persists to argue that FSIAD and MHSDDD can be “calculated, fixed and treated” (Flore 2014: 45), ignoring the social, psychological and cultural contexts of (a)sexual expression, experience and emotional response (Crankowski and Milks 2014).

Bogart (2008) and Brotto and Yule (2010) generally agree that asexuality can be differentiated from HSDD and FSAD because asexual identified individuals are not distressed by their ‘lack’ of sexual desire, but Bogart (2008) and Brotto and Yule (2010) both disregard the fact that identifying with a relatively invisible label could cause distress in and of itself, and that given the relative invisibility of asexuality many people diagnosed with HSDD or FSAD may not even know of its existence (Carrigan 2011).

The DSM V distances asexuality from the medical model and presents an asexual identity as stable, fixed and without potential for fluidity, despite a clear refusal of such notions within the asexual community (Carrigan 2011, Przybylo 2011, Scherrer 2008).



Through distancing asexuality from the medical model, the DSM V creates a binary differentiation between those who are asexual and those who are not. The DSM suggests that you cannot have a *sexual* dysfunction if you identify as *asexual*, by positioning a diagnosis of FSIAD or HSDD as impossible when an individual identifies as asexual. The dismissal of a diagnosis of FSIAD or HSDD when the individual self-identifies as asexual pathologizes asexual practices and simultaneously creates a further erasure of asexual identity: that is to say, asexual practices, or an expression of a ‘lack’ of sexual desire or attraction, are pathologized through the diagnoses of FSIAD and HSDD, which on paper reflect the practices expressed by much of the asexual community, whilst the DSM’s clause at the same time prohibits a diagnosis of FSIAD or HSDD for self-identified asexuals, and so erases asexuality further. The DSM positions asexuality as something both pathological and almost non-existent simultaneously, unlike homosexuality which was both pathologized and legitimized by the DSM naming it, asexuality does not gain legitimacy through the DSM’s recognition of it due to the DSM positioning asexuality as an identity category, rather than something innate. The tension present in the DSM, also plays out in the contemporary asexual community on the AVEN, where there is a push to legitimize asexuality through claiming it as an innate and preclusive sexual orientation and yet also a pressure to complicate contemporary asexuality and its definition in order to be as inclusive as possible (see further discussion on pages 75-81).

The DSM neglects asexuality in its categorizations of ‘appropriate sexuality’, and in the most recent edition explicitly excludes asexuality from its seemingly exhaustive list of sexual dysfunction. Through the DSM asexuality becomes doubly erased, not only is asexuality understood through the DSM as a refusal of heterosexuality in a heteronormative society, but also as a refusal of the DSM’s conception of sexuality and ‘sexual function’ all together.

### **3.4 Conclusion**

Where Krafft-Ebing’s (1886) concern was with reproduction or rather with ‘perversions’ that prevented it, Kinsey’s (1948, 1953) concerns lay with orgasm. Kinsey’s (1948, 1953) works neglect ethical, social or emotional factors and isolates

‘orgasm’ as the subject, relegating ‘sexual perversions’ to psychiatry (Potts 2002). Where Krafft-Ebing (1886) locates naturalness in reproductive sex, Kinsey (1948, 1953) locates ‘naturalness’ in sexual behaviour, or orgasm (Potts 2002). In turn Krafft-Ebing (1886) pathologizes (a)sexuality through his categorizations of *anesthesia sexualis*, and *asexuality*, where individuals who experience little or no sexual desire are regarded as either worthy of psychiatric study, and thus ‘ill’, or as having physiological abnormalities; where as Kinsey (1948, 1953) erases (a)sexuality on his scale of sexual response, leaving only its trace in the form of ‘X’ participants included in his tables. Both the works of Kinsey (1948, 1953) and Krafft-Ebing (1886) have persisted to haunt the DSM. The DSM V distances asexuality from the medical model in the same way that Kinsey (1948, 1953) refuses to analyse the results of ‘X’ participants despite their prevalence, by refusing to legitimise its existence in its most recent diagnostic criteria. The DSM V lists two gendered ‘sexual dysfunctions’ that are similar to the experiences of participants Kinsey (1948, 1953) records as ‘X’, and Krafft-Ebing (1886) categorizes as ‘suffering’ from *anesthesia sexualis*. By refusing to acknowledge asexuality as something innate, the DSM V renders asexuality an identity category, outside of Western medical discourses of legitimacy, and thus doubly erased.

## **4. Politicization**

In the following chapter I intend to explore the absent presence of (a)sexuality in socio-political moments involved in visibility advocacy. I argue asexuality's erasure from these contexts has come to be through the climates and discourses of the 1960s and 1970s, which have silenced (a)sexuality's resistant potential in capitalist Western society. I turn first to examine how we tell liberation stories, drawing on the work of Hemmings (2005) and Plummer (1995) to explore the ways in which stories of liberation have come to be told in a cohesive and unified manner, and how we might go about telling them differently. Political movements are often held up as defining moments of a community and have been retold many times in multiple forms, but the proliferating stories of social movements are often rose-tinted and gloss over or ignore integral foundational moments, the erasure or increased marginalization of others, or disregard the unintended implications outcomes have on others.

Using the work of Hemmings (2005) and Plummer (1995) alongside my methodological framework (See Chapter 1) I then turn to a case study focusing on the gay liberation movement, followed by a discussion of feminist movements and the ways in which their narratives have shaped contemporary understandings of asexuality. I will then move to the current period to address contemporary asexuality through the *Asexuality Visibility and Education Network* (AVEN) and the asexual movement that has evolved alongside it. I recognise the case studies included in this chapter are both complex and multifaceted, and due to the constraints of the thesis I address only parts of the assemblage where I can through my limited case studies, but I argue the parts of case studies presented can be taken a representative of wider socio-cultural responses to discourses during the mid to late 19<sup>th</sup> Century.

### **4.1 Telling Liberation Stories**

Stories of liberation have come to be remembered, told and re-told, as cohesive and linear narratives, which gloss over or ignore instances and moments that disrupt their linearity, but are also affective and have the ability to move us (Hemmings 2005). Plummer (1995) discusses narratives of coming to a marginalized identity as part of

establishing not only a sense of self, but also a connection in relation to a wider world or community; as hooks (1989: 43) has noted “oppressed people resist by identifying themselves as subjects, by defining their reality, shaping their new identity, naming their history, telling their story”. Weeks (1991) contended that a quest for identity has been hugely significant to those marginalized by Western norms, especially for those labelled as sexually deviant. In this sense telling stories for Plummer (1995) becomes a way not only to identify yourself, but also to identify yourself in relation to others and the world around you.

Examining the work of Weeks (1991), hooks (1989) and Plummer (1995) it becomes increasingly evident as to why the repetition of the same liberation stories has become commonplace in contemporary Western society. Through the repetition of liberation stories, such as the Stone Wall Inn riots of 1969, or Feminist bra burning, gendered and sexual minorities of the past century have enabled the solidification of an identity that has been the subject of infinite question and scrutiny in Western society. Plummer stated “a crucial strategy of story telling is the creation of a sense of past which helps to provide continuity and order over the flux of the present” (1995: 40). But in repeating the same liberation stories we position history against the present just by naming it, and in telling the same liberation stories we “*lay down routes to a coherent past, mark of boundaries*” (Plummer 1995: 172 emphasis in original), simplifying the differences and discarding what is deemed unimportant or that which interrupts the linear progress of narratives (Hemmings 2005). This chapter will consider the ways in which boundaries have been marked off, erasing asexuality from liberation stories due to its troubling not only of heterosex, but also of other penetration-centric critiques of sexual politics.

Liberation stories can be understood to “lead the tellers in some directions and not others” (Plummer 1995: 173). It is these ‘other’ directions that my research is concerned with exploring; not to privilege them over the histories that we already know so well, but to pay attention to the multiplicity present within history. As outlined in my methodology (see Chapter 1), I take a genealogical approach, not in the hope of discovering the ‘real’ ‘truth’ of any given moment, movement, or approach, but to provide a critical account of familiar histories where (a)sexuality has become an absent

presence through its erasure. Hemmings (2005: 118) highlights that by acknowledging, “there is no single historical truth” we do not have to understand history as “simply a matter of individual opinion” or consider “all truths... somehow equal”. Rather, we should be conscious that the multiplicity of historical truths might enable an awareness of political responsibility in contemporary society (Spivak 1999).

Plummer describes stories being constructed from a series of ‘props’, and that these “‘props’ are deposited in a trail behind” as “a life is lived” (1995: 36-37). The trace of (a)sexuality can therefore be understood as a series of ‘props’ that have been left behind throughout history, that are now used to construct contemporary stories of asexuality. Each ‘prop’ takes the shape of a node within the assemblages, moving through them at each point shifting and changing the shape of the assemblages that they exist within. Considering asexuality as the trace of a node within the assemblages of medicalization, pathologization and politicization that work to erase asexuality, we could understand these traces of nodes as manifesting themselves as props that interact, affect, and transform both the shape and trajectory of asexuality. It is the litany of ‘props’ within each assemblage enables the heterogeneity and instability of contemporary asexual identities, and the stories that they are constructed around.

In the following chapter therefore I intend to examine the “props” (Plummer 1995: 36-37) that are left as a trace behind the stories of liberation movements that we are told. In doing so I intend to explore why these stories are told, where the traces of asexuality have become an absent presence in liberation stories, and how liberation stories have shaped contemporary asexuality (Hemmings 2005, Plummer 1995, Spivak 1999). As Hemmings (2005: 119) argues, “my primary aim is to open up future possibilities” for asexuality “rather than dwelling on past omissions”. I consider the genealogical excavation of “past omissions” (Hemmings 2005: 119) as the means to consider what possibilities these “props” (Plummer 1995: 36), or traces (Derrida 1976), of asexuality might open up for Western heteronormative society.

## **4.2 Gay Liberation Movement**

Robinson (2003:1) argues “gay history has developed against...silences”, it is the silent moments of Lesbian, Gay, Bisexual, Trans and other sexual or gendered minorities

(LGBT+) history's that I intend to explore in the following section. LGBT+ movements have a long and extensive history, dating back to well before the narratives of sexual liberation in the 1960s and 1970s that we have become so familiar with. I start this subsection with a discussion of the Boston marriages of the early 19<sup>th</sup> century (Kahan 2013, Scott and Dawson 2014), to complicate normative narratives of LGBT+ movements before turning to address some of the most prominent groups within the gay liberation movement of the late 1960's. It is recognised that the movements covered in this subsection largely centre on gay men in a Western context, despite often being presented or remembered as representative of the wider LGBT+ community; I use this Chapter to tease apart some of the convolution that arise from this 'misremembering'. For the purposes of this analysis, I will primarily focusing on the gay liberation movement in America, as America is also where AVEN was established. I acknowledge that there are voices and identities that are further marginalized by the decision to focus on American social movements, however, as the contemporary asexual community on AVEN is understood to be largely White-American, in tracing its history I have sought out moments when it has been erased from its own context.

Through exploring the silences present within LGBT+ histories I seek to trace the ways in which (a)sexuality has been erased from the dominant narratives of sexual liberation and remained (in)visible despite the emergence of a visible LGBT+ movement where a 'lack' of (hetero)sexuality is also present (Love 2009). Love (2009) argued that there is "a tendency to read the queerness of queer desire as excess rather than lack, but it would also make sense to understand queerness as an absence of or aversion to sex". Love (2009) describes queerness as being able to be conceptualised as a 'lack' of sex (when sex is understood to be heteronormative), much in the same way that (a)sexuality is understood in contemporary Western society as a 'lack' or 'absence'. The 'lack' of heteronormativity present within both queerness and (a)sexuality provides sufficient grounds to draw on the gay liberation movement for my next case study tracing asexuality. Throughout the 1960s social liberation movements located the body as a site of political struggle, and marked sexuality as holding the potential for emancipation (Fahs 2010).

Before turning to examine the gay liberation movement in America, as an aside, I first want to discuss the Boston marriages of the late 19th century in order to complicate the taken-for-granted history of LGBT+ movements ‘beginning’ during the 1960s. The phrase ‘Boston marriages’ has been used to describe the long-term partnerships between women who lived together. There has been considerable debate on whether these relationships were celibate or sexual, complicated by the medical discourses discussed in Chapter 2 that positioned ‘sex’ as only being possible between a husband and wife (Foucault 1978, Kahan 2013). Kahan has argued that the debate between whether Boston marriages should be considered celibate or lesbian relationships is unhelpful, suggesting instead, that regardless of the practices of women involved these relationships, they can be understood to “share a social identity with celibacy” (2013: 41). The claiming of Boston marriages as lesbian relationships could be understood as an erasure of (a)sexual practices, by contemporary Western LGBT+ movements. However, the Boston marriages indicate one of the earliest instances of a social and political rejection of the institution of marriage in Western society, where Boston marriages provided one of the only options for women to have social and economic independence from men (Kahan 2013).

Armstrong and Cragge (2006) argue that the Stonewall riots of 1969 are often heralded as the pivotal moment of LGBT+ history. On the 27<sup>th</sup> of June 1969 New York police raided the Stonewall Inn as part of an on-going operation targeting the unlicensed selling of alcohol; police frequently targeted so-called ‘deviant’ bars or venues during raids. However, on this occasion patrons of the Stonewall Inn decided to resist arrest and sparking a riot. The Stonewall riots were not the first instance of LGBT+ resistance during police raids, nor were they the first to spark social or political organization in their aftermath. However, others have failed to be remembered in the same way (Armstrong and Cragge 2006, Hall 2008). As Weeks (2007: 19) argues, the emphasis on the Stonewall riots has made it “impossible to think of ways of being non-heterosexual today which cannot trace their roots back to the emergence of gay liberation after 1969”. I therefore turn to address the political organization and social change that emerged following the Stonewall riots, to examine the ways in which the gay liberation movements have simultaneously shaped and rendered (a)sexuality invisibility.

Two main groups dominated the gay liberation movement; the 'Gay Liberation Front' and 'Gay Activists Alliance'. The Gay Activists Alliance was the first political organisation in the United States of America to lobby city and state government for Gay and Lesbian rights (Schiavi 2011); it will therefore be my focus for the following section. Stein (2012: 79) describes the post-1960s gay liberation movement as signifying "unprecedented mass mobilization and unparalleled social change". During the decade following the Stonewall riots, socio-political movements became increasingly visible. The Gay Liberation Front formed in the United States within the months following the 1969 June Stonewall riots, and the Gay Activists Alliance held its first meeting in December of the same year. The first meeting of the Gay Liberation Front in the United Kingdom was held at the London School of Economics (LSE) in 1970 alongside the first 'Pride' march, which took place in New York.

In the years following the Stonewall riots, activists and groups worked to confront the pathologization of homosexuality by the DSM, and set about providing community organized social initiatives to gay men and women to challenge discrimination within the medical profession (Hall 2008). In addition to the socio-political organisation within gay communities there was a proliferation of gay newspapers, sports teams, book stores, and community lead helplines or social services, the pressure of which eventually lead to homosexuality being declassified as a mental illness in 1973 in the DSM (Hall 2008).

Each of these events marked a major development in the liberation of gendered and sexual minorities, but they all have largely been attributed to the Stonewall riots, erasing "the long history of pre-Stonewall struggles" (Stein 2012: 80). Taylor (2011: 335) writes that "in celebrating new queer presences the absence of 'others' must also be considered", and there is an absence of (a)sexuality not only within the social movements that have fought for gay liberation, but also within the wider context of the increased visibility of marginalized gendered and sexual subjectivities, which I address in this subsection through a case study of the Gay Activists Alliance.



Utopian activists during the late 1960s had hoped that the liberation of sexuality would provide a challenge to global capitalism (Weeks 2007). However, as Foucault (1978) highlights, whilst visibility can be argued as necessary for a process of change or transgression, visibility also opens up the possibility for assimilation to the normative, and activism forces a certain reification of its focus. LGBT+ social movements have achieved many arguably ‘positive’ things in Western society (see for example McCormack and Anderson 2010). However, the visibility they have achieved has also enabled the commodification of homosexuality, and the assimilation of homosexuality to heteronormative standards of the ‘good life’ (Ahmed 2010, Duggan 2002). Pride events have become increasingly commercialised, and whilst many argue that ‘big’ sponsorships can be considered beneficial for the community, others feel marginalized and ignored as a result of the ‘celebrations’ of ‘equality’ that for them has yet to be achieved (Jeppesen 2010). Weeks (2003: 93) argues that neoliberal capitalism has sped up the “dissolution of traditional structures” and “encourage[d] the process of ‘individualization’”. However, using Ahmed’s (2010) work we can understand gay liberation movements and the growing process of ‘individualization’ (Weeks 2003) as providing a visibility that enabled an assimilation of homosexuality to the normative Western model of capitalist consumption, rather than viewing the proliferation of gay and lesbian literature, cinema, newspaper and other commodities as transgressive.

The propagation of literature and other commodities framed as for ‘sexual minorities’ can also be understood as having erased (a)sexuality. Asexuality does not conform to Western heteronormative sex-centric narratives of a ‘good’ life, but nor does it fit into the ‘sexual deviant’ or marginalized stories of homosexuality, bisexuality, or trans experiences. (A)sexuality has been rendered invisible through Western societies’ understandings of what it means to be (a)sexual, which has hinged on a ‘lack’ of sexual desire. A ‘lack’ or ‘absence’ of sexual desire in the climate of commercialisation and capitalism present in Western societies has positioned the (a)sexual as a bad economic subject, through the assumption that a ‘lack’ in sexual desire must also result in a ‘lack’ of interest in commodities that are marketed as sexual (Lazzarato 2009, for further discussion of the asexual as a bad economic subject see pages 36-37 in Chapter 2).

Social and politically organised groups such as the Gay Liberation Front and the Gay Activists Alliance frequently used political pamphlets as a means to disseminate their work to a wider audience. One example of these political pamphlets is the Gay Activists Alliance (1974) *20 Questions about Homosexuality: A Political Primer* (see Fig. 4). The pamphlet was primarily aimed at challenging the social abjection of homosexuality and the perception that homosexuality was a pathological illness (Gay Activists Alliance 1974). The Gay Activists Alliance (1974) pamphlet set out a series of 4 key demands; the right to their own feelings, the right to love, the right to their own bodies, and the right to be persons (see Fig. 4). The pamphlet opens with the statement “we as liberated homosexual activists demand the freedom for expression of our dignity and value as human being through confrontation with and disbarment of all mechanisms which unjustly inhibit us: economic, social, and political” (Gay Activists Alliance 1974: 2). It also relied heavily on the work of Kinsey (1948, 1953) and Freud (1951) to legitimize homosexuality, reinforcing the hetero/homo binary and discounting the possibility of anything outside of hetero/homosexuality. In attempting to legitimize homosexuality the Gay Activists Alliance (1974) positioned sexuality as something universally experienced, binary and static, erasing the possibility of anyone who does not experience sexual desire or exhibit sexual behaviour. In relying on the work’s of Kinsey (1948, 1953) and Freud (1951) to legitimize homosexuality, experiences of (a)sexuality were erased, much in the same way as Kinsey (1948, 1953) excluded ‘X’ participants from his scale of sexual behaviour (see pages 48-53 for further discussion of Kinsey).

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#### Figure 4. Gay Activists Alliance (1974)

However, the Gay Activists Alliance was heavily criticised by trans-exclusionary radical feminist Morgan (1973), for their low levels of female participation and conformity to hegemonic masculine and misogynistic practices. In Blasius and Phelan's (1997) collection of gay liberation stories Morgan (1997: 428) criticizes the Gay Activists Alliance remarking "Are we to forgive and forget the Gay Activist Alliance dances...at which New York GAA showed stag movies of nude men raping nude women?". However, in the paragraph following this, Morgan (1997) discounts the experiences of trans women, describing them as obscene and insulting, calling on others to prevent them from participating in activist groups (Blasius and Phelan 1997). Morgan's (1997) statements highlight the fragmentation and tension present within the

social movements of the late 1960s and early 1970s. Social movements are often remembered as cohesive and unified, with only ‘positive’ or ‘progressive’ outcomes, ignoring the complexities and diversities present within such movements. Cases such as Morgan’s (1997) account demonstrate the male dominated make-up of the Gay Activists Alliance and other gay liberation movements, but also the tensions present within the gay and lesbian community, and their intersections with the feminist movement, that all too often served to further marginalize others in their quest for ‘equality’.

We can understand (a)sexuality as being written out of the history of gay liberation, as a strategic response to discourse much like Kinsey’s (1948, 1953) erasure of ‘X’ participants. Discourses at the time resulted in a push to legitimize homosexuality through medically essentialist notions of sexuality, and the particular uptake of the work of Kinsey (1948, 1953) and Freud (1951) led to the propagation of their work being viewed as helpful to the deconstruction of homosexual oppression. Whilst the works of Kinsey (1948, 1953) and Freud (1951) contributed significantly to the declassification of homosexuality as an illness, their adoption by gay liberation movements led to the continued propagation and promotion of sexuality as biologically innate, static, and something that could be categorized or defined by medicine. The uptake of medical works by the gay liberation movement enabled a further marginalization of gendered or sexual minorities outside of the hetero/homo binary, and contributed to another instance of (a)sexual erasure. In addition, the discourses of individualization encouraged by gay liberation movements in the context of capitalist Western society facilitated yet further erasure of (a)sexuality, positioning those who did not contribute economically to society through the pursuit of sexual pleasure as bad economic subjects.

### **4.3 Feminist Movements**

I now turn to discuss the relationships between historical feminist movements and (a)sexuality. I seek to deconstruct the period of 20<sup>th</sup> century feminism and the familiar narrative Western feminism has told of its history (Hemmings 2005). I choose not to limit this case study to a specific decade or ‘wave’ of feminist movement, not in order to convolute and homogenise feminist history, but rather to complicate it; as Braidotti (1991) highlights it is in many ways “dangerous to propose a purely theoretical

representation of this multiple, heterogeneous complex of women's struggles". Instead I intend to analyse the conflicting interpretations and understandings of feminist movements, to highlight the multitude of differences present within it, and revalue "the currently sidelined traces" (Hemmings 2005: 131) of asexuality that dominant narratives have erased or ignored. I use feminist writings as "a window into one moment" of thought (Gerhard 2000: 450).

Hemmings' work highlights that Western feminism gives a narrative of feminist theory and movements that divides the past into clear decades "to provide a narrative of relentless progress" (2005: 15); arguing that this narrative "oversimplifies" (2005: 16) differences in feminist thought and activism. Braidotti (1997) expands, claiming that the dominant narratives of the progress of feminism erase the heterogeneity of individual traces and that certain biographies are privileged as a result (Hemmings 2005, Spivak 1999). I therefore turn to pay particular attention to the ways in which the cohesive and linear narrative of feminism that has emerged has contributed to the erasure of (a)sexuality. I map the traces of (a)sexuality within 20<sup>th</sup> century feminism and its movements, paying attention to the heterogeneity of the practices, meanings and interpretations of both (a)sexuality and feminism.

The shape of feminism has undergone significant transformation throughout the 20<sup>th</sup> century. Suffrage campaigns of the early 1900s subscribed to 'medical' models that positioned male and female sexuality as 'naturally' different, often oppositional and static or unchangeable. However, despite these differences, Weeks (1989: 163) writes that "what unified all feminists was a desire to ease the burdens of motherhood", but that the ways and means considered necessary to do so were divisive within the movement. Some feminists advocated complete chastity in order to resist Western notions of the 'family' that privileged patriarchy as an institution (see historic articles from Densmore 1968, O'Donnell 1968 and Oliver 1912), whilst other feminists called for the availability and use of artificial contraception (Weeks 1989). However, the ultimate goal remained to allow women control of their own bodies, often homogenised under the rubric 'our bodies, our lives'.

Koedt's (1968) work is largely regarded as the first and most significant challenge to the institution of heterosexuality (Gerhard 2000). Koedt drew attention to the ways in which female sexuality is "defined... in terms of what pleases men" arguing that women were "fed a myth of the liberated woman and her vaginal orgasm, an orgasm which in fact does not exist" (1968: 11). Koedt (1968) did not align clitoral orgasm with a specific sexual identity, but rather a form of female sexuality that transcended socially assigned terms. In doing so Koedt's (1968) work marked a major break in Western sexual and feminist thinking, in a context where psychiatric, physiological and medical works of Kinsey (1948, 1953), Freud (1914) and Krafft-Ebing (1886) were still privileged and drawn on to legitimise sexual difference (Gerhard 2000). Koedt's (1968) work pursues the clitoral orgasm as a tool harnessing emancipatory power to challenge patriarchal understandings of female sexuality. In contrast, Oliver (1912) argued that the only way women could avoid conforming to patriarchal norms of sexuality was to take a complete vow of chastity, in order that women avoided becoming "slaves" (1912: 252) to their "lower appetites" (1912: 252) in the same way that men had. However, both Koedt's (1968) and Oliver's (1912) arguments are flawed in the sense that they both serve to marginalise others. Koedt (1968) dismisses the idea that there may be women who do not wish to orgasm or who do not find clitoral stimulation pleasurable, whilst Oliver stigmatizes women who have "lower appetites" (1912: 252).

The struggle between understanding the body as a site of socio-political power and at the same time understanding the body as a source of pleasure and physical experience "has represented a central dilemma in the feminist movements of the past 40 years" (Fahs 2010: 446). Milks (2014) has argued that the sexual revolution of the 1960s and 1970s, led by feminists and gay activists, ignored asexual women because it assumed they were repressed. The rejection of chastity or non-orgasmic sex by certain 'sex positive' feminists led to the advocacy of better contraceptive choices and the assertion of clitoral orgasm and sexual pleasure as an entitlement. However, those who did not wish to claim their 'entitlement' to sexual pleasure or clitoral orgasm were 'othered' by differing feminist sects that understood the refusal to uptake the demand for clitoral orgasm as 'sex negative'. In contrast some feminist schools of thought claimed (a)sexual practices, or celibacy, as a radical refusal of the cultural context of sexual

liberation that some feminists argued promoted women's sexual availability (Przybylo and Cooper 2014).

Cell 16, a militant feminist organisation most active during the late 1960s and 1970s, prescribed a programme of celibacy and self-defence to women (Echols 1989). Cell 16 relied on essentialist binary explanations of gender as biologically innate and 'naturally' different to discourage homosexuality, claiming it was prevalent within feminist organisations as a response to the pervasiveness of heterosexuality, but that it was only a 'personal' solution to a societal problem (Echols 1989). In the first of Cell 16's series of *No More Fun and Games: A Journal of Female Liberation* publications Densmore (1968: NP) argued that the major problem with liberation was "a supposed 'need' for sex". Densmore (1968: NP) went on to underline that "sex is not essential to life, as eating is. Some people go through their whole lives without engaging in it at all, including fine, warm, happy people". Parallels can be drawn between Densmore's (1968) description of people who go through life without having sex, and Krafft-Ebing's (1886) patients' K. and W. who report no discomfort at their lack of sexual interest and live seemingly happy lives (see pages 45-46 for a discussion of Krafft-Ebing's (1886) patients).

However, Densmore (1968: NP) also goes on to explain, "We are programmed to crave sex. It sells consumer goods. It gives a lift and promises a spark of individual self-assertion in a dull and routinized world". Here Densmore (1968) slips into essentialist notions that sexual desire is innate and natural. On one level Densmore's (1968) argument implies that not engaging in sex is revolutionary and politically emancipating, through demonstrating a rejection of capitalist consumption and a refusal of masculine defined sexual norms. Yet at the same time Densmore simultaneously erases the possibility of (a)sexuality, through the assertion that "We are programmed to crave sex" (1968: NP), so that not engaging in sex is only radical, revolutionary or politically emancipating if you abstain from sex by making a conscious choice to repress sexual 'cravings'. The trace of (a)sexuality can be understood as being an absent presence in the work of Densmore (1968), who identifies the possibility of living a "fine" life

without sex, but also simultaneously erases the possibility of a genuine lack of interest in sex.

Fahs (2010) argues that the uptake of asexuality in feminist debate could become a useful tool to deconstruct the binary of sex positive and sex negative feminist debates. For Fahs (2010) 'sex positive' feminist movements used the assertion of sexual pleasure as a right, to construct sexual 'freedom' as synonymous with freedom to have more sexual activity or partners, and experience more physical pleasure. The emphasis on these forms of sexual 'freedom' has left (a)sexuality noticeably absent from the dominant narratives of the 'sexual revolution' (Fahs 2010, Milks 2014, Przybylo and Cooper 2014). The assumption that sexual liberation relied on having more pleasurable and non-heteropentratve/normative sex, erased the experiences of those who felt a 'lack' or 'absence' of sexual desire or a desire for sexual pleasure, and those that did not find sex pleasurable. However, as demonstrated through articles published by Cell 16 (Densmore 1968, O'Donnell 1968, Oliver 1912) 'sex negative' organizations also instigated an erasure of asexuality, through the assumption that celibacy only held political potential for those that experienced and then repressed sexual desires.

This subsection has discussed Przybylo and Cooper's (2014) reading of feminist celibacy as a form of asexuality, and Fahs (2010) contrasting call to embrace asexuality as a way to deconstruct the sex positive/negative dichotomy. I have used Foucault's (1972: 211) understanding that "discourse is not life: its time is not your time", to describe the ways in which the singular is always privileged by history despite multiple meanings. In line with Foucault's (1972) thinking I have not sought to distinguish whether or not examples of celibate feminist movements can be read as asexual. I have instead sought to identify the absent presence of the trace of asexuality within feminist movements of the 20<sup>th</sup> century. Cell 16, for example, encouraged an abstinence from all sexual activity, and their written work can be read as harbouring evidence of the erasure of (a)sexuality within 'sex negative' movements in a way which Fahs (2010) ignores. In publications (see Densmore 1968, O'Donnell 1968) Cell 16 also imply that there is no healthy possibility of experiencing little interest or desire for sex. I therefore read the publications and writings of Cell 16, Densmore (1968), Koedt (1968), Oliver (1912),



and O'Donnell (1968) as 'props' (Plummer 1995) containing the absent presence of (a)sexuality (Derrida 1976) that has remained missing from the liberation stories we tell. These traces of asexuality present within feminist movements of the 20<sup>th</sup> century have functioned to shape contemporary understandings of asexuality, which I shall now address through a case study of the *Asexuality Visibility and Education Network* (AVEN).

#### **4.4 The Asexuality Visibility and Education Network**

In the following subsection I now turn to explore the *Asexuality Visibility and Education Network* (AVEN) and its definition of contemporary asexuality. I seek to trace the establishing moments of AVEN, and the ways in which historic traces of (a)sexuality have haunted and shaped contemporary understandings of asexuality. In the following subsection I will be examining the history of the AVEN, exploring the ways in which it was established, and how the AVEN has shaped the face of contemporary asexuality. I draw further attention to the complexities present within the asexual community that make asexuality increasingly difficult to define.

American activist David Jay founded the AVEN in 2001 as an internally hosted site at Wesleyan University, originally established after Jay had struggled in defining his own identity due to lack of available resources. During the turn of the 21<sup>st</sup> century the internet was fast expanding and, within the same year Jay founded the AVEN, Wikipedia was also founded, Apple launched iTunes, and 54% of U.S. households had Internet access (U.S. Department of Commerce 2004). Mosbergen (2013) writes, "at the time, asexuality, beyond a purely biological definition was almost completely unheard of... to most of the world". Jay has spoken to press on multiple occasions (see Mosbergen 2013, Sohn 2005) about his rationale behind the community and the founding of the AVEN commenting he knew "that asexual people have been looking for each other for a long time, but it wasn't until the Internet that we found each other" (Mosbergen 2013: NP).

One of the first written traces of Asexuality online is highlighted both in Jay's accounts of AVEN's beginnings and in Hinderliter's (2009) history of definition; 'My Life as an Amoeba' (O'Reilly 1997). Hinderliter (2009) noted that throughout the 90's people

would post about something that resembled asexuality on message boards, but these platforms did not offer people space to respond. However, O'Reilly's (1997) article, posted to the now non-existent *StarNet Dispatches*, provided the first notable platform for asexual discussion online. The article called for "the world to know that we are out there" (O'Reilly 1997: NP). *StarNet Dispatches* had space for comments, and 'My Life as an Amoeba' prompted response from asexuals around the world (although most likely to be U.S. or U.K. based) calling for a community and space to interact.

In response to 'My Life as an Amoeba' the most significant pre-public-AVEN asexual community was established as a Yahoo! group, known as 'Haven for the Human Amoeba' (HHA) in 2001 (Hinderliter 2009). The group remained inactive for its first six months of operation, despite a steadily growing membership, with its first discussion not being instigated until the following year when the group's creator queried people joining without saying anything. From this point on discussion was sporadic until around July 2007 when people began posting more regularly. HHA still exists, although is considerably less active today. According to Hinderliter (2009) a number of other early asexual community sites that have since ceased to exist are still accessible as static pages via the Internet Archive, however, due to the inconsistency of language at the time and their often obscure names these sites are difficult to find without explicit prior knowledge of their existence, in this sense early asexual community sites can be considered a trace of themselves.

AVEN was made public and first established its forums in 2002, and slowly began its rise to prominence as the largest asexual community online. Hinderliter (2009) puts forward a number of arguments as to why AVEN overtook its competitors in popularity, including; its domain name being memorable (asexuality.org), its superior design, and the forums enabling multiple conversations to occur simultaneously. However, it is arguable that the most significant factor could be AVEN's external hosting. Previous groups and communities were reliant on existing sites for hosting, including the Yahoo! group HHA, and the Live Journal (LJ) community, which the AVEN had close links with. Externally hosting the AVEN enabled them to climb up Google's search results, making them more easily findable by those outside of the community.

Another aspect of AVEN's lasting popularity in the asexual community is its direction. Where other platforms primary focus was to encourage conversation, AVEN encouraged members to engage with each other and their own wider communities outside of the Internet. The current incarnation of AVEN claims to have two main objectives; to facilitate public acceptance and discussion of asexuality, and to enable to growth of the asexual community (The Asexuality Visibility and Education Network 2015). Since beginning its growth has been substantial and it now boasts over 70,000 members from across the world, making it the largest recorded asexual community (The Asexuality Visibility and Education Network 2015). The site attempts to serve as an informational resource for those who identify as asexual, are questioning their a/sexuality or for family and friends of asexual identified people. The AVEN (The Asexuality Visibility and Education Network 2015) encourages members to "regularly engage in visibility projects" including "distributing information pamphlets, leading workshops, arranging local meet-ups and speaking to interested press".

Hinderliter (2011) highlights that AVEN's definition of asexuality marks asexuality as intrinsic and as something that is defined independently of an individual's own identity. Throughout AVEN's 'HOME', 'ABOUT AVEN' and 'ABOUT ASEXUALITY' pages there is a continual distancing of asexuality from celibacy. The first paragraph of the 'ABOUT ASEXUALITY: Overview' pages reads:

"An asexual is someone who does not experience sexual attraction. Unlike celibacy, which people choose, asexuality is an intrinsic part of who we are. Asexuality does not make our lives any worse or any better, we just face a different set of challenges than most sexual people. There is considerable diversity among the asexual community; each asexual person experiences things like relationships, attraction, and arousal somewhat differently. Asexuality is just beginning to be the subject of scientific research". (The Asexuality Visibility and Education Network 2015)

The excerpt above from AVEN (2015) defines celibacy as behavioural and a ‘choice’; marking celibacy as in complete contrast to asexuality, which is defined as “intrinsic”. This definition is not a new addition or even an evolution: Hinderliter (2009) notes AVEN’s definition of asexuality has remained static since it first went public. There have been a number of debates on the definition both within and outside the forums hosted by AVEN, however, Hinderliter (2009: NP) notes “most people didn’t seem to want to change the definition because they recognised that any definition” would “run into similar problems” because “there is no perfect definition of asexuality”. David Jay’s own argument has been that AVEN’s public definition is intended for people outside of the asexual community and that within the asexual community the accepted definition is “anyone who calls themselves asexual” (Hinderliter 2009: NP). However, through opposing the relationship between celibacy and asexuality so strongly the AVEN (2015) marks asexuality as something that cannot be chosen and is inherently fixed. Defining asexuality as “intrinsic” and inherent is problematic not only because so much of the AVEN’s (2015) own community reject this understanding, but also because such a definition positions asexuality as a fixed and static orientation; privileged over identity. Though as Hinderliter (2009) recounts there have been a number of discussions of definition within AVEN community and given the public-facing nature of AVEN’s (2015) definition of asexuality, and the length of time it has remained unchanged it could be considered that AVEN’s (2015) definition has in fact shaped the community, rather than the community shaping the definition in the way Jay has argued (Hinderliter 2009, Mosbergen 2013, Sohn 2005).

In defining asexuality, and therefore the contemporary asexual community, AVEN (2015) has drawn on ‘scientific’ and ‘medical’ research in an attempt to legitimise asexuality as a sexual orientation. Parallels can be drawn here between AVEN’s (2015) reliance on ‘scientific’ research to legitimise asexuality and the Gay Activists Alliance who drew on the work of Kinsey (1948, 1953) and Freud (1951) in an attempt to legitimize homosexuality in the 1970s (see pages 68-70). Whilst the quest for legitimacy can be understood as assimilation to Western normative understandings of sexuality, the lived experiences of those who seek legal recognition for their identity must not be disregarded. AVEN (2015) also argue that legal recognition and legal

legitimacy of asexuality could lead more people to ‘discover’ an asexual identity, because it has remained relatively invisible in Western socio-cultural contexts that favour heterosexuality.

However, on the same ‘ABOUT ASEXUALITY: Overview’ page AVEN (2015) positions asexuality as an identity category by arguing “If at any point someone finds the word asexual useful to describe themselves, we encourage them to use it for as long as it makes sense to do so”. Through its definitions of asexuality AVEN (2015) is in constant contradiction and tension with itself, by attempting to distance behaviour from identity. Hinderliter (2011) argues that distancing behaviour from identity is in fact impossible as well as unhelpful and instead we should be concerned with how the two interconnect and relate.

Contemporary asexuality as an identity is self-understanding and cannot be separated from its current historical social contexts. We can understand historic medical practices (discussed in Chapter 2, see pages 23-34) as haunting contemporary understandings of asexuality outside of medicine. Historical understandings of hysteria have persisted to haunt both contemporary medical practices associated with an ‘absence’ or ‘lack’ of sexual desire, and in turn the contemporary asexuality community on AVEN. Gordon (2008, 2011) conceptualises haunting as a form of disappearance from recognition. Using Gordon’s (2008, 2011) conceptualisations of haunting, we can consider the haunting of contemporary medicine by hysteria as erasing asexuality from recognition. The current edition of the Diagnostic and Statistical Manual (DSM) includes two diagnoses that closely parallel the definitions of asexuality given by the *Asexuality Visibility and Education Network* (The Asexuality Visibility and Education Network 2015, American Psychiatric Association 2013), but also include sub-clauses in their diagnostic criteria to prevent a diagnosis being made if the individual self-identifies as asexual (see pages 53-59 in Chapter 3 for further discussion of asexuality and the DSM). Asexuality, whilst being explicitly mentioned, is simultaneously delegitimized by the DSM’s refusal to diagnose or ‘treat’ those who identify as asexual. This is not to say that asexuality *should* be or requires treatment, rather that asexuality becomes an absent presence that instead persists to both haunt and be haunted by concealed histories

(Kuntsman 2011). Biological essentialism, psychiatry, heteronormativity and Western sex-centrism, upheld by medicine, have determined that asexuality should be understood as a biologically innate ‘lack’ or an ‘absence’ of what is considered ‘normative’. Within AVEN asexuality is presented as “intrinsic”, and whilst AVEN also acknowledges asexuality is not a fixed or stable identity for everyone, that argument is not presented until much further down their definition page, creating a hierarchy of asexuality where biologically essentialist notions of orientation are privileged over identity.

Przybylo and Cooper (2014) have understood the AVEN (2015) as a public archive and ‘face’ of asexuality, whilst they highlight the biologically essentialist definitions of asexuality given by the AVEN they also highlight the space created for more diverse and individually bound definitions of asexuality through the forums attached to the AVEN. Ultimately though, Przybylo and Cooper (2014) argue that asexuality has narrowed in definition since the rise of the web and that asexual community platforms such as the AVEN have contributed to the narrowing of definition. There are also considerable problems with the majority of existing research on asexual identity and definition; as the majority of academic research has relied on participants from the AVEN subjects can only be self-identified asexuals, ignoring those who may practice (a)sexuality but haven’t yet come to an asexual identity yet.

In conclusion to this subsection, whilst AVEN has contributed significantly to an increased visibility of asexuality, this visibility has only reached certain sections of society; largely white and largely Western. The shape of AVEN has not only been determined by historical traces of (a)sexuality located by this thesis within the works of Kinsey (1948, 1953), Krafft-Ebing (1886), Freud (1951), but is also haunted by the traces of liberation movements including the Gay Activists Alliance (1974) and Feminist movements (see pages 66-70 for discussion of Gay Activists Alliance and 70-75 for discussion of asexual erasure in Feminist movements). Through the uptake of these traces AVEN has shaped the identifiable definition of contemporary asexuality, and in turn its own community.

#### **4.5 Conclusion**

This chapter has argued that the politicization assemblage has facilitated the uptake of traces of medical and psychological understandings of (a)sexuality as a means to legitimize its existence. The attention paid to the ways in which certain forms of visibility have resulted in an assimilation of liberation movements to ‘normative’ Western standards has again underlined how asexuality has been erased by Western society. I have again emphasised how a ‘lack’ or ‘absence’ of sexual desire in capitalist societies has rendered the asexual as a ‘bad economic subject’, through the assumption that a ‘lack’ of desire to consume sex is synonymous with a ‘lack’ of desire to consumer commodities marketed as sexual. Through an exploration of the diversity and heterogeneity of liberation histories that are often presented as linear and homogeneous narratives, I have illuminated the traces of (a)sexuality that have shaped the contemporary online community AVEN (2015). In paying attention to the complexity of liberation histories I have understood the texts analysed as ‘props’ (Plummer 1995), which contain the absent presence of traces of asexuality. I have deliberately avoided limiting the case studies drawn on to a specific decade, in order to complicate understandings of Western liberation histories. In doing so I have illuminated “currently sidelined traces” (Hemmings 2005: 131), to underline the ways in which their erasure persists to haunt contemporary asexuality and dominant understandings of what asexuality is.

## **Conclusion**

In conclusion, this thesis has argued that instances of asexuality precede the Internet, and that its existence has instead been erased through the series of complex and multi-faceted discourses that have spanned recent history. I have traced the existence of asexuality in a Western context through the late 19<sup>th</sup> century up to contemporary society, understanding asexuality as an absent presence within Western historical documents. I have examined the interconnections of medicalization, pathologization and politicization assemblages that have erased asexuality. I have come to understand the erasure of asexuality as a product of capitalist Western society, where asexuals have been framed as ‘bad economic subjects’ (Lazzarato 2009) through their refusal to consume sex in normative ways.

I have argued the importance of listening to silences when researching a subject that is claimed to be culturally or socially invisible, drawing on the work of Mazzei (2007), Dyer (1997) and Black (2011). The research has examined how socially and culturally invisible subjects can become haunted by their unspoken or erased histories through the work of Cvetkovich (2003) and Gordon (2011, 2008). In creating a methodological framework for researching asexuality I have sought to combat the ontological complications of researching an invisible subject, which is also understood to exist only through a ‘lack’ or ‘absence’ of something, through drawing on the work of Derrida (1976). Through careful genealogical enquiry I have traced asexuality via a series of complex and heterogeneous assemblages, arguing for an embracement of what asexuality *can do*, rather than what it *is* or *is not* (Deleuze and Guattari 1987, Fox 2012). In understanding asexuality as a trace of a node within the assemblages of medicalization, pathologization and politicization I have enabled new understandings of asexuality as something with an agency of its own, in constant flux and non-definable.

Through an account of the medicalization assemblage using case studies of female ‘hysteria’ and ‘frigidity’, and the rise of Viagra, I have examined the ways in which sex has become framed as a necessity in Western society. I have analysed the ways in which discourses surrounding ‘normative’ sexuality positioned an ‘absence’ or ‘lack’ of sexual desire as in need of medical intervention and treatment (Maines 1999). Through



Foucault's (1989) work surrounding the medical gaze, I have explored how the privileging of the body in medicine enforced the notion that 'treatments' should work on the 'surface' ignoring complexities and individual differences in identity, behaviour and experience. I have explored the ways in which developments in 'science' and a shift away from religion in line with enlightenment thinking at the time facilitated the implementation and marketing of Viagra. I draw attention to how medical discourses serve to regulate and control society, and regulate (a)sexuality through its erasure (Foucault 1978). The exploration of the medicalization assemblage has enabled an understanding of asexuality's erasure as "meaning full" (Mazzei 2007: 29); as opening up possibilities to transgress Western hierarchies of relationships that privilege the sexual (Przybylo 2011).

In the pathologization chapter I have highlighted the ways that asexuality was rendered invisible through the psyche. In drawing on the works of Krafft-Ebing (1886) and Kinsey (1948, 1953) I have established the ways in which a 'lack' or 'absence' of sexual desire was legitimized as a psychological disorder. I have mapped the evolution of the diagnosis and categorization of psychological 'disorders' surrounding a 'lack' or 'absence' of sexual desire through the Diagnostic and Statistical Manual, which has refused to legitimize asexuality despite naming it. Through the pathologization assemblage I have considered the ways in which (a)sexuality has become a prisoner of heteronormativity, and the institutions, histories and disciplinary technologies which uphold it by silencing or pathologizing everything outside of (hetero)penetrative sex. I have drawn attention to the ways (a)sexuality can be re-presented through Black's (2011) work, so that the haunting of (a)sexuality by psychiatry can be understood as transformative. Rather than understanding asexuality through a 'lack' or 'absence' I instead present the traces of asexuality as harnessing transgressive potential through their shaping of the future.

I have also explored asexuality within the politicization assemblage. Using the work of Plummer (1995) and Hemmings (2005) I have drawn attention to the ways in which we retell liberation stories and how these retellings have shaped social movements. I have examined how the gay liberation movement and feminist movements have further

erased asexuality through their activism, whilst creating sciences. I have drawn on the work of Foucault (1972) to underline the privileging of the singular histories despite their complexities. An analysis of the gay liberation movement has illuminated asexuality's erasure as a strategic response to discourses at the time. I have underlined the ways that medical works were drawn on to legitimize homosexuality, and how the uptake of Kinsey's (1948, 1953) works further marginalized gendered and sexual minorities outside of the hetero/homo binary. Through an exploration 20<sup>th</sup> century feminist movements I understand feminist texts as 'props' (Plummer 1995) that contain the absent presence of the trace of asexuality (Derrida 1976). I have traced the ways in which these 'props' have contributed to the shape of contemporary asexuality (Plummer 1995).

Finally I have underlined the ways in which the assemblages of medicalization, pathologization and politicization have shaped contemporary asexual movements, and the online community on the *Asexuality Visibility and Education Network*. I have highlighted the complexity of asexuality, and its historical traces prior to the Internet. This work has understood asexuality in new ways, outside of medical frameworks that have positioned asexuality as an innate 'lack' or 'absence' of sexual desire, and beyond the confines of the online community AVEN. My methodological framework has presented a new way of researching socially or culturally invisible objects, and enabled an understanding of asexuality as multi-faceted, complex and un-definable. In doing so, the research provides groundwork for future studies on invisibility, asexuality and other 'new' sexual subjectivities that are largely understood as products of contemporary mediated society.

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## **Appendix**

### 1. Desk-Based Research Ethics Approval



#### Desk-Based Research Ethics Approval

This project involves using materials already in the public domain and does not involve human participants

#### Project Title

### **A Genealogical Analysis of Asexuality**

#### Principal Investigator Certification

I believe that this project <b>does not require research ethics approval.</b>	X
I confirm that I have selected this option because it honestly describes the risk associated with my project.	X
I confirm that I will carry out the project in the ways this application describes (see project summary, comments and attachments if proffered). I will immediately suspend research and request a new ethical approval if the project subsequently changes.	X

#### Principal Investigator

Name: Joshua Price .....

Date: 19/11/2014 .....

#### Student's Supervisor (if applicable)

I confirm that I have discussed this project with the student and agree that it does not require research ethics approval. I will continue to review ethical issues in the course of supervision.

Name: Adrienne Evans .....

Date: 19/11/2014 .....

### **Desk Based Research Ethics Approval Checklist**

#### Applicant Details

Project Ref:	P29503
Full name:	Joshua Price
Faculty:	[AD] School of Art and Design
Department:	[AX] Computing and Media
Module Code:	M004MRDC
Supervisor:	Adrienne Evans
Project title:	A Genealogical Analysis of Asexuality
Date(s):	01/12/2014
Created:	19/11/2014 16:09

#### Project Details

A Genealogical Analysis of Asexuality.
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